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The Last Available Option: Young Adults Who Attempt Suicide

by

Robin Donne Everall ©

A thesis submitted to
the Faculty of Graduate Studies and Research
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Doctor of Philosophy

in

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled "The Last Available Option: Young Adults Who Attempt Suicide", submitted by Robin Donne Everall in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counselling Psychology and School Psychology.

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DEDICATION

To take on a project the size of which is required for completion of a doctoral dissertation was a huge undertaking. In an already busy life, room had to be made to read, to explore, to think, to write, and to focus. Each of these tasks required time that had previously been used for some other important purpose in life. Something needed to be sacrificed. For me, the sacrifice was made in time with my friends and family, those people who make my life meaningful. I would like to thank them for their patience and understanding, for their love and support, for making and keeping me accountable, for their belief in my ability, and for putting up with a neglectful parent, family member, and friend. I have been blessed with wonderful friends and family who each made an important and irreplaceable contribution to the completion of this dissertation. Although those contributions may not have been acknowledged, they did not go unnoticed.

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ABSTRACT

Young adults constitute one of the highest risk groups for suicide attempts in Canada. Five young adults were interviewed about the thoughts, feelings, and events that contributed to their suicide attempts made between the ages of 20 to 24. Four of the five participants had also attempted suicide between the ages of 10 and 15. Qualitative data were collected and analyzed to develop descriptions that explored life experiences prior to the suicide attempt. These narratives were subsequently evaluated within the framework of current suicide research. A review of the literature revealed that suicidal behavior is construed as either acute, emphasizing crisis oriented approaches to treatment, or chronic, stressing the interpersonal and problem-solving nature of the suicidal behavior. In contrast to these positions, the compiled stories and thematic analysis produced "a sense of personal coherence" that does not fit well into any one of the prevalent suicidal models. The participants discussed issues of recurrent disruption within the family, accumulated losses, perceptions of lack of connection and communication with peers or valued adults, and lack of control over life events or outcomes, all of which were identified as beginning in childhood and continuing into adolescence and adulthood. For these individuals, the path toward attempting suicide appeared to be a process that spanned childhood to early adulthood, developing through accumulated life experiences.

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Chapter One

Introduction

The aim of this study was to investigate young adults' perceptions of the psychological and developmental processes that culminated in their suicide attempts. The nature, meaning, and impact of the life events and psychological stressors that preceded and contributed to each of their decisions to attempt to take their own life were investigated. In addition to eliminating the possibility of uncertainty and bias introduced by obtaining information from third party informants, the advantage of relying upon personal interviews is that a valuable understanding of the human experience and human process can be obtained.

In this study, young adults were interviewed who were between the ages of 20 to 24 when they made the decision and took action to end their own lives. Interviews of the participants allowed for the exploration of important personal events, the meaning those events had for each individual, the extent to which they influenced the participants' perceptions and cognitions about their lives, and the affective responses associated with the suicide attempt. The role of life events and the psychological impact of these events varied in individual cases. Whereas the subjective interpretations of specific events played a critical role in the suicidal process for some individuals, similar events and experiences did not have the same impact for others.

My interest in this topic began following a return to university to pursue a career in psychology. One of the degree requirements was to work with clients in a supervised setting for several months. One client, a young woman in her mid teens, was referred for counselling following a suicide attempt. She had, and was continuing to experience, extreme difficulties in almost every aspect of her life, but particularly with her family and with school. She had been moved to a foster home placement away from her friends and peer group. Professionals responsible for her care who had

been involved with her over the course of several months were concerned about her mental health and the possibility that she may attempt to take her life a second time. As a fledgling therapist, I found working with this girl was anxiety-provoking and challenging as the complexity of her situation became more and more apparent to me.

Throughout the therapeutic process it became evident that her thoughts, feelings, and behaviors which had initially appeared to be relatively straight forward, were in reality, highly complex and difficult to tease apart. When discussing her experience, perceptions of life, and her suicide attempt specifically, she would frequently tie issues together that outwardly appeared unrelated. Thoughts, feelings, behaviors, and events were linked together for her in a manner that created meaning, but one that was difficult for an observer to understand without close and careful listening and exploring of issues.

Her influence left a strong impression on me and led to the recollection of a family member's experience with suicide when a junior high school classmate took his life unexpectedly. Losing a classmate at such an age raised new issues that had been previously unexplored and the process of questioning and wondering about life began in a search for answers. The topic of suicide arose frequently as he struggled with understanding the event, his feelings that resulted from it, his observations of what could have been different, and his general grappling with the meaning of life. As he struggled with attempting to understand why and how the classmate had made the decision to take his life, I found myself accompanying him in a search for understanding. My heart went out to the young boy who had found it necessary to engage in such a final act of self destruction. What leads a person to such a decision?

In both my personal and professional capacity, the questions that are raised by suicide and suicidal behavior continue to present themselves frequently. When turning to the literature to find something on the direct experience of those who struggle with suicide, there is little available. In the search for portraits one finds only crude sketches.There has always been some vague sense that understanding the reality of the suicidal person was

important and possible. As a psychologist, it seemed imperative.

The questions concerning suicidal behavior in young adults that were investigated in this study are as follows:

- What was the psychological reality of suicidal individuals prior to their decision to commit suicide?
- What psychological needs contributed to and affected the decision to attempt to take their own lives?
- What were the individuals perceptions of the environmental factors that contributed to the decision to engage in the suicidal behavior?
- What were the personal factors that contributed to their decision?

Importance of the study

In Canada, suicide is the second leading cause of death after accidents for young adults between the ages of 20 to 24. Suicide rates for this age group increased dramatically in the 1970's and has remained at approximately the same level since. With the increased completion rate, it is logical to assume that the attempt rate has increased also, although no specific figures are available. The high rate of youth suicide in the past decades has been a subject of particular concern to researchers, clinicians, and the general public. Understanding the quality of interpersonal relationships, life events, and ultimately the meaning of the individual's actions and experiences is crucial to a more comprehensive conceptualization of suicidal behavior. There has been little qualitative research about the actual process of, and the psychological realities that contribute to, the decision to end one's life from the point of view of the person most intimately involved, the attempter of suicide. Rather, researchers have tended to focus on third party evaluations of motivation and intent.

An increasing incidence of suicidal behavior raises a societal alarm that indicates the need to examine the underlying causes and factors that

may affect suicidal behavior for both males and females (Mazza & Reynolds, 1994). A person who decides to engage in suicidal behavior has his or her own unique constellation of affect, cognition, and meaning that contributes to their decision. Life events, their interpretations, and their meanings, occur within the psychological framework of individuals. Studies that provide detail pertaining to individual reactions to life stressors and their psychological implications are useful in providing a sound basis for the development of responsive prevention and intervention programs. Additionally, studies of those who have acted on their suicidal inclinations are necessary in adding to the body of psychological knowledge concerning the vulnerability of some individuals that may predispose them to choosing suicidal behaviors as a way to address life's dilemmas (Sigurdson, Staley, Matas, Hildahl, & Squair, 1994).

Definition of Terms

The words used in discussions of suicidal behavior are inconsistent across disciplines and terms are often used interchangeably across studies even though they are not consistently defined. The result is often confusion in the interpretation of results when incompatible comparisons are made. The terms to be used within the context of this study are as follows.

Throughout this document, the term **suicide** refers to any act with a fatal outcome that is deliberately initiated and performed in the knowledge or expectation of its fatal outcome. **Attempted suicide** includes behaviors that stem from a serious suicidal intention, however the individual has been unsuccessful in his or her conscious effort to end life, usually because of an unplanned event. The use of the term **parasuicide** is used when describing a deliberate act of self-harm when the individual has no specific intent to die. The use of this term also includes suicidal gestures and behavior aimed at creating desired changes that occur as a result of the self-harm behavior. **Suicidal ideation** is the thought involved in thinking about death, one's own or the death of others, of planning one's own death,

contemplating consequences and the impact that death would have on one's environment. Suicidal ideation can occur for short periods once in a lifetime or can be long term. The individual who has attempted to poison him or her self by carbon monoxide but was inadvertently discovered and rescued would be considered a suicide attempter whereas the individual who ingested an overdose of aspirin but after a short period of time changed his or her mind about wanting to die and discloses this to another individual probably would be considered parasuicidal. An individual who did not think a large dose of aspirin was lethal would also be considered to be parasuicidal.

Scope, Purpose, and Significance

This study focussed on those who had attempted suicide in young adulthood, specifically between the ages of 20 to 24. The primary goal of the researcher was to obtain a deeper understanding of the meaning of suicidal behavior for the individuals who volunteered to participate in the study. Those who participated were individually interviewed about the perceptions, beliefs, and emotions that impacted the suicide attempt. A semi-structured interview approach was used so that each participant could relate their experience using their own structure and language.

There were several assumptions in choosing to study such individuals. It was assumed that those who have made attempts against their life in the past but who are no longer suicidal have the emotional energy, time, and interest to consider participating in the research project. It was also assumed that those individuals who volunteered to participate were doing so because of an interest in sharing the experience and knowledge they gained with others. Those who may benefit are professionals who deal with suicidal clients, individuals with a general interest in the area for personal reasons, researchers who continue to explore and expand the knowledge in this field and the general public in which the understanding of suicidal behavior continues to be deficient and the perception is maintained that suicide and suicidal behavior are enigmas. Individuals who continued to

perceive of themselves as being suicidal were not approached for participation as this might create further risk to life that would be considered unethical.

Order of Presentation

In Chapter Two, Review of the Literature, the current avenues through which suicidal behavior is being investigated are discussed in an attempt to illuminate the context of suicidal behavior and suicidal thought. Various rationales and explanations for suicidal behavior and completed suicide emerge from this context.

In Chapter Three, Methodological Considerations, issues are addressed concerning the general philosophical orientation that provided the basis for this research project, that being qualitative research approaches, and the relationship of method to phenomonology. The chapter outlines the parameters used to select and interview participants in the study. It also provides a description of data analysis procedures and ethical considerations.

In Chapter Four, Introduction to Participants, a detailed description of each of the participants is provided through the use of a brief biographical description. The study included four females and one male, all of whom attempted to commit suicide between the ages of 20 to 24.

Chapter Five, Results, is a presentation of the analysis of the data obtained through interviews with the participants. Themes that emerged as a result of careful examination and evaluation are presented and substantiated by excerpts from transcripts of the interviews. Commonalities and differences are identified between each participant's experiences in an attempt to show the coherence of the experience while retaining the personal nature of each.

Chapter Six, Discussion, consists of the identified themes which are integrated with the reviewed literature. Conclusions are also discussed within the context of existing literature. Implications for further research and therapy are discussed.

Chapter Two

Review of the Literature

Epidemiological Data

Suicide

Canadian suicide rates have remained somewhat stable for both males and females between 1985 and 1992, the last year for which statistics are available (Update of the Report of the Task Force on Suicide in Canada, 1994). In the Task Force report, however, there is concern expressed about the prevalence of suicide in the young adult population that has continued to increase since the 1950's, particularly among young men. In 1992, suicide was the fifth leading cause of death across age groups and accounted for approximately 1.9 percent (3709) of all deaths in Canada. In the 20 - 24 age group, 374 young adults committed suicide, 306 males, 68 females.

Suicide is the second leading cause of death after accidents in young people aged 15-24 (Mazza & Reynolds, 1994; Sigurdson, Staley, Matas, Hildahl, & Squair, 1994). Indeed, it has been recognized that suicidal risk increases with increased age, placing young adults at higher risk for suicidal behavior than late adolescents. The increase in suicide rates over the past several decades, particularly for young people, has been well documented (Bland, Newman, & Dyck, 1994; Kralik & Danforth, 1992; Rossow & Wichstrom, 1994; Shneidman, 1985; Sigurdson et al., 1994). Males and females tend to utilize different methods of suicide. Males tend to employ firearms, hanging, or gassing techniques whereas women tend to choose poisoning or hanging. Only 25 to 40 percent of persons who complete suicide have a history of a previous attempt (Update of the Report of the Task Force on Suicide in Canada, 1994)

The 1992 and 1993 suicide statistics in Alberta indicate that there was a dramatic increase in the number of individuals who committed suicide

between the ages of 20 to 24 as compared to the 15 to 19 age group. Twenty to twenty four is the age range at which the highest ratio of attempted to completed suicides occurs (Bland et al., 1994), and it has been consistently reported that the lifetime prevalence of suicide attempts declines with age after young adulthood.

The ratio of reported suicide attempts to suicide completions is higher in young women than in young men, whereas the ratio of suicide completions to reported suicide attempts is higher in young men than it is for young women. In 1992 and 1993 in Alberta, there were 61 completed suicides by males between the ages of 20 to 24 compared to 18 completed female suicides. Additionally, Alberta suicide rates are second only to Northwest Territories in Canada. (Update of the Report of the Task Force on Suicide in Canada, 1994).

Attempted Suicide

As many individuals who attempt suicide never receive medical assistance or psychological attention and there is no formal documentation of the attempt, no definitive statistics about suicide attempt rates are available (Bland et al., 1994; Diekstra, 1993; Mazza & Reynolds, 1994). Additionally, many suicide attempts are misclassified as accidental. As a result, the statistics estimating attempts to completions vary significantly from the very conservative 10:1 to a liberal 1000:l. What little information is available concerning suicidal behaviors has been gathered through the psychiatric community and is based largely on results obtained on individuals diagnosed as mentally ill.

A study of suicide and suicidal behavior conducted in Canada found that ten percent of adults made a suicide attempt in their lifetime while thirteen percent made plans for suicide (Ramsay & Bagley, 1985). In a review of worldwide trends of suicidal behavior Diekstra (1993) stated that the majority of suicide attempts are made by individuals below the age of 35. Approximately ten times as many people make a non-fatal suicide attempt as those that result in death (Diekstra, 1993), although some estimates

range as high as one thousand attempts for every completed suicide (Strosahl, Chiles, & Linehan, 1992). Suicidal gestures are also estimated to occur 10 times more often than failed or completed suicides (Mann, DeMeo, Keilp, & McBride, 1989). One of the striking features of suicide statistics is the preponderance of males that complete suicide compared to the many of females who attempt suicide (Rossow & Wichstrom, 1994), a feature that appears to be stable across both North America and Europe.

Changing Conceptualizations of Suicidal Behavior

The historical view that suicide and attempted suicide constitute different parts of the same behavioral phenomenon, differentiated by outcome, has gradually been abandoned. This view conceived of suicidal ideation, suicidal gestures, suicidal behavior, and completed suicide as falling on a linear continuum of intensity with suicidal ideation at one end of the spectrum and completed suicide at the other (Linehan, 1986). Such a conception infers that an individual would proceed along that continuum from least serious to most lethal in a sequential, progressive fashion. It is commonly accepted by suicidologists, however, that many individuals engage in suicidal ideation only rarely while some almost continually. Many individuals make serious attempts to end their life based upon a strong impulse and not having engaged in prior suicidal ideation (Roy, 1982), whereas others who purposefully and thoughtfully plan to end their life never engage in the behavior (Maris, 1981).

There is mounting evidence to suggest that those who commit suicide comprise a different population from those individuals who attempt suicide; each population with its' own distinct characteristics (Bland et al., 1994; Diekstra, 1993; Linehan, 1986; Mazza & Reynolds, 1994; Rossow & Wichstrom, 1994; Shneidman, 1985). Diekstra (1993) discusses completed suicide, suicide attempts, and parasuicide as "a stepwise hierarchy of suicidal actions with an underlying gradient of severity or fatality risk" (p.17). He views completed suicide and suicide attempters as separate but overlapping populations with differential characteristics. Others

conceptualize suicide ideators, suicide attempters, and suicide completers as three separate but overlapping populations.

Demographic Characteristics

Regardless of whether suicide attempters are conceptualized as a separate population, there are certain demographic characteristics that have been identified and generally accepted in the literature. The following characteristics are usually included.

- Attempters are more likely to be female than male with an estimated ratio of 2 or 3:1 in all age groups in Edmonton (Bland et al., 1994), however estimates range as high as 1000:1 in North America (Strosahl, Chiles, & Linehan, 1992) for attempts to completions.
- The peak risk period tends to be between the ages of 20 to 24 (Bland et al., 1994). As previously mentioned, the higher rates of suicide attempts are produced by the younger populations (Mazza & Reynolds, 1994; Shneidman, 1985; Sigurdson et al., 1994).
- Suicide attempters tend to be single, divorced or separated, and most often live alone (Bland et al., 1994; Shneidman, 1985; Sigurdson, 1994).
- Seventy to ninety percent of all attempts result from drug overdoses in Edmonton (Bland et al., 1994), a figure consistent with reports from other regions of the world (Carrigan, 1994; Strosahl et al., 1992).

Drug overdose appears to be the choice of suicidal method for young people, particularly females, whereas males tend to use other methods such as hanging, slashing, or poison, as well as and in conjunction with, drug overdoses. Many studies indicate that alcohol plays a large role in the actual suicide attempt, and that alcohol is used in conjunction with other methods such as drug overdose, slashing, or carbon monoxide poisoning.

Although demographic variables provide important information about at-risk groups, they add little to a theoretical understanding of the phenomenon. Despite our knowledge of the variables associated with suicidal ideation, attempts, and completed suicides, there continues to be

little precision in predicting suicidal behavior, controlling suicidal behavior, or even directing therapeutic interventions within a suicidal population.

Theoretical Perspectives

The causes and motivating factors of suicide and suicidal behavior have been investigated and explained from a variety of psychological points of view. The perspective through which suicide and suicidal behavior is understood helps determine not only the intervention and prevention strategies to be used in a given circumstance but also provides a framework for interaction with suicidal individuals, family members, or the community at large. For example, if suicidal behavior is conceived of as being manipulative in nature, the individuals engaged in those behaviors are more likely to encounter hostility and resentment from helping professionals and significant others. If on the other hand, suicidal behavior is perceived to be the result of extreme psychological trauma or pain, the suicidal individual may be the recipient of more empathic understanding. Additionally, the methods and variables thought to be relevant to the subject of inquiry are chosen on the basis of theoretical perspective and provides a framework within which to evaluate results.

The influential theories of our time have tended to group suicidal behavior and suicidal people together in ways that allow for the identification of specific, theoretically relevant characteristics. While several theorists have been successful in identifying demographic variables related to the higher risk categories of suicidal behavior, they have focussed upon identifying groups rather than individuals (Hughes & Neimeyer, 1990). As such, efforts to predict and control suicidal behavior have been marginal at best. Each theory however, has added valuable information to our understanding of the phenomenon.

Psychoanalytic Theories

Freud's theory (Freud, 1977) was based upon the conceptualization

of suicidal activity as a phenomenon essentially in the mind of the individual (Slimak, 1990) rather than emphasizing the external factors that are generally motivated by unconscious intentions. His theory has provided the conceptual framework for psychological investigation in suicide (Leenaars, 1988) and provides the foundation for the psychoanalytic approach to understanding and explaining suicidal behavior. It is based upon the premise that the suicidal individual is reacting to the experience of loss or rejection of a significant other. Although one acted as if he were killing himself, Freud hypothesized that his intent was to kill a significant other as well as himself. Feelings of aggression and revenge toward the other party, which culminate in depression, were considered to be turned inward within the suicidal act. While both wish fulfillment and self-punishment acts were seen as the motivation for suicide, these were thought to reside at the subconscious level.

Building on Freud's conceptualization, Menninger believed that suicide was determined by external and internal factors that contributed to the construction of reality for the individual (Leenaars, 1988). He stated that the act of suicide involved three important components: the act of dying, the act of killing, and the act of being killed, each of which were defined by conscious and unconscious motives. The motives were expressed through guilt, anger, and the desire to end pain (Leenaars, 1990).

Consistent with the psychoanalytic tradition, Menninger posited that unconscious motivations were more reliable and significant than conscious motivations. Ambivalent attachments with others, or the sudden interruption of attachments contributed to a wish to kill, turned toward the self. The wish to die was produced as a result of a relative weakness in developing meaningful relationships with others. Overall, Menninger stressed that suicidal behavior was not typically the result of a single cause or event, but was motivated by many preliminary events.

George Kelly contributed significantly to the study of suicide by emphasizing that people give meaning to events rather than discovering meaning in events (Leenaars, 1990). Therefore, meaning was considered to be personally constructed, and any number of alternative meanings were

thought to be possible in any given situation. Kelly theorized that suicide was a constrictive gesture occurring in response to anxiety created by the identification of the self as helpless in understanding a seemingly senseless world. Suicidal people were unable to see possibilities and options. For some individuals an inability to predict events often resulted in hostility toward the environment or to those who functioned within that environment. The result was that they created social alienation. For others, an inability to select an appropriate single course of action was thought to cause alienation from others. Therefore, suicide was seen as a mechanism of giving meaning to life, because no other tenable alternatives were available to deal with the threat of living.

Kelly also postulated that the suicidal individual recognized that personal change was required in order to function effectively in the environment, but the individual perceived this as too threatening. Kelly made a significant contribution to our understanding of suicidal behavior by attempting to explain the behavior from the suicidal individual's perspective rather than from a psychopathological perspective. The act of suicide or attempting suicide has meaning for the person engaged in it.

Henry Murray conceptualized suicide as a functional act which intentionally eliminated the pain and suffering being experienced. Unsatisfied needs were seen as being manifested in emotional states such as desperation, misery, and distress. Suicide was perceived by the individual as the relief of psychological pain. Shneidman (1985, 1987, 1993a), to be discussed at length in a following section, based his theoretical approach on that of Murray.

Current psychoanalytic theories are supportive of the notion that life's traumas are too much to bear for suicidal people and too many of their personal needs are being frustrated, which results in their excessive pain. These theories each have the same four meaningful components to them: situation, relationship, emotional state, and cognitive state. The situation in which the person finds them self is perceived of as traumatic, although it may not appear so to an objective observer. Although the suicidal person may identify a specific cause of their trauma, a variety of traumas have most likely

contributed to the decision making process. Suicidal activity may be the person's solution to disturbed or disturbing relationships and may be an outcome of frustrated wishes for closeness or connection. Distress, grief, and desperation are emotions commonly reported by suicidal individuals. The suicidal person experiences a sense of being overwhelmed and overpowered by emotions and that are often of an ambivalent nature. The disturbed cognitive state is experienced through the anticipation of more pain than pleasure in the future. As a result, the individual sees little justification for continuing to live. Contradictory thoughts and attitudes are evident in the individuals perceptions and ideas.

Cognitive-Behavioral Perspective

Proponents of the cognitive-behavioral perspective, another major theoretical school, posit that one of the major factors differentiating suicidal from non-suicidal individuals is the content of their belief systems. This is best represented by the work of Beck and his associates (Beck,1986; Beck, Kovacs, & Weissman, 1975; Beck, Steer, Beck, & Newman, 1993; Beck, Steer, Kovacs, & Garrison, 1985) who believe that suicidal behavior is associated with depression, and more specifically, hopelessness. Beck identified negative expectation of the future as critical to the construction of suicidal ideation, in addition to the perception that suicide was the only alternative to a situation conceptualized to be unsolvable. Death is therefore considered a desirable alternative to living. A negative view of self, manifest through behaviors such as self-blame and self-criticism, contribute to feelings of lack of personal worth. Essentially, Beck's theory identifies cognitive components as primary sources and affective states as secondary responses to the cognitive experiences of the individual.

The attribution model of hopelessness ties together negative events, hopelessness and deficits in coping skills (Jack & Williams, 1991). Individuals whose attributions are stable, internal, and anticipate global failure may have reduced expectations of future success, a negative perception of self-efficacy, and reduced motivation and persistence in

addressing life's obstacles. Therefore attributions may play a mediating role between suicidal behaviors and adverse life events. While controlling for mood over time, Jack and Williams (1991) reported that in comparison to non-suicidal medical patients and non-patient controls, suicidal patients consistently hold "dysfunctional attributions in the face of multiple adverse events" that "promote the hopelessness and deficits in coping styles" (p. 33).

As knowledge is acquired and cognitive functioning becomes more complex, the identification of rigid versus flexible thinking patterns has increasingly became identified as an essential framework from which the individual interacts with the world. The identification of rigid thinking in individuals with depression has moved cognitive theorists to explore and generate a second line of research into problem solving abilities, coping mechanisms, and interpersonal skills. Studies will be discussed in depth in a following section.

Social Learning Theory

Social learning theory, represented by the work of Diekstra (Diekstra, 1993; Diekstra, Maris, Platt, Schmidtke, & Sonneck, 1989) is based upon the premise that suicidal behavior is learned from, and reinforced by, experiences in the environment. The expression of anger is turned inward, as the individual has learned throughout their childhood that overt expressions of anger are inappropriate. Childhood experiences placed within an environmental context create the atmosphere that fosters suicidal thoughts and actions. Environmental reinforcers are hypothesized to exert a strong influence over the individual. Depression is seen as a critical contributing factor to suicidal behavior in addition to under socialization because of failure to internalize accepted cultural norms. From this perspective comes the pervasive belief that suicidal behavior is often motivated by the desire to manipulate others.

Multidimensional Perspective

Shneidman (1985, 1987, 1993a), Maris (1981), and Leenaars (1988, 1990) fall into the multidimensional perspective that incorporates components from the psychoanalytic, cognitive-behavioral, and social learning theories. The multidimensional perspective emphasizes the interaction of personality, environment, and learning processes from which suicidal behavior is developed. Suicidal behavior is hypothesized to be complicated by a compilation of a painful situation, a constricted cognitive state, overpowering emotions, and disturbing relationships, and is conceptualized as adjustive but not adaptive. The distressed individual perceives suicide to be as the only available option at the time. Death provides a solution to end conscious awareness of pain.

Shneidman (1987) proposed a Cubic Model to explain suicidal behavior which is comprised of three closely interconnected components; pain, press, and perturbation. Pain incorporates psychological pain that results from unmet psychological needs and spans a range from little to intolerable pain at either end of the spectrum. Press incorporates internal responses and action to both internal and external events and ranges from positive to negative. Perturbation is the degree of distress or upset experienced as a result of internal and external realities.

Leenaars (1988, 1990) contributed a developmental perspective to the theory. He emphasized that suicidal ideation, suicidal behavior, and suicide attempt ratios vary across the lifespan. Suicidal ideation has been shown to vary with age, with younger adults experiencing a higher level of ideation, while middle aged and older adults experience a lower level of suicidal ideation but a higher completion to attempt ratio.

Young adults between the ages of 18 to 25 frequently describe their situation as unbearable and view suicide as an effective method of removing the pain. Most frequently, a disturbed interpersonal relationship is reported as the source of distress for young adults. In addition, inwardly directed aggression is more prevalent in the younger versus the older population. Younger adults are more harsh, self-depreciating, self-blaming, and self-

critical when compared to more mature adults. Interestingly, however, the older population clearly demonstrates a stronger wish to die and demonstrates a lower attempt to completion rate which separates them from both the young adult and middle aged adult groups.

Maris (1981) conceptualizes suicidal behavior within the context of suicidal careers. He theorizes that suicide is rational, "an effective means of resolving common life problems" (p. 290). He also contends that suicide is not always intentional, that suicidal individuals tend to have ambivalent feelings about living, and that meanings of suicidal behavior vary. He further presents the argument that non-suicidal alternatives have been either unavailable or unacceptable, that suicide is available as a resolution, that tolerance thresholds have been repeatedly breached, that self-destructive behaviors significantly lead to suicidal behavior, and that negative interpersonal relationships contribute to suicidal behavior.

Psychological Characteristics

Shneidman (1985) differentiated the suicide and suicide attempt populations, not so much on the basis of demographics, but rather on the basis of psychological characteristics. The psychological approach places a primary emphasis on thoughts, feelings, and behaviors, not on the neurological, physiological phenomena that is that used in the psychiatric approach (Shneidman, 1989). Shneidman (1985) differentiated the populations as "suicide" in which he includes those who intended to die, but whose actions were thwarted, and "parasuicide" who are individuals who engage in suicidal gestures without the intention to die. Whereas he identified both suicide and parasuicide as sharing the stressor of frustrated psychological needs, he differentiated parasuicide on the basis of the following psychological characteristics.

Parasuicidal persons experience severe, but endurable psychological pain whereas suicidal individuals are believed to perceive the pain as unendurable (Maris, 1981; Shneidman, 1985). The purpose of the parasuicidal behavior is to evoke a response and is enacted within an

interpersonal framework, with the intended outcome being to "reorder the life space and. . .decrease discomfort" (Shneidman, 1985, p.217). The parasuicidal person is more disconnected and disenfranchised from others, experiencing both loss and rejection, rather than the total hopelessness and helplessness experienced by the suicidal individual. The suicidal person who has come to terms with their decision to end their life can therefore move beyond their distressed emotional state to one that is calm and resigned whereas the parasuicidal person cannot move beyond their distressed emotional state. Lastly, the parasuicidal individual is expressing a plea for engagement with others and an end to their state of unhappiness (Shneidman, 1985).

Suicidal and parasuicidal individuals, as well as those who have failed suicidal attempts, have historically been conceived of as psychiatric cases (Carrigan, 1994; Jack & Williams, 1991; Kral, 1994; Rich, Fowler, Fogarty & Young, 1988; Shneidman, 1985, 1993a, 1993b). However, the evidence that the majority of parasuicides result from serious psychopathology is equivocal at best (Jack & Williams, 1991; Shneidman, 1985, 1993a). The psychopathological explanation of suicidal behavior may result from an understanding of suicidal behavior as outside the realm of "normal" behavior. Additionally, this perception may be fostered by the majority of studies of suicidal behavior that utilize convenient and accessible psychiatric or psychiatric in-patient populations.

There is a growing interest, however, in examining the biopsychosocial factors that may be associated with suicide attempts rather than mental illness per se (Diekstra, 1989; Heikkinen, Aro, & Lonnqvist, 1993; Kral, 1994; Shneidman, 1985; Shneidman, 1993). In addition, the interacting variables of meanings and environmental factors that mediate an individual's decision to engage in suicidal behavior (Boldt, 1989) are increasingly being investigated. The shift in focus from the biological/medical model to a more comprehensive model is a result of a growing interest in multidisciplinary approaches in the study of suicide and suicidal behavior. As each profession contributes specific knowledge acquired in their field to the more general body of knowledge, it becomes

increasingly clear that suicidal behavior can only be truly understood through multidisciplinary approaches. The current state of knowledge concerning the multifaceted and intricate factors that contribute to suicidal behavior is currently insufficient for a thorough understanding of the phenomenon.

To address the issue of a more complete understanding of suicide and suicidal behavior, Shneidman (1993b) stated that suicide should be viewed as "a phenomenological event, a transient tempest in the mind" (p.146). He explained suicidal behavior as adjustive, as opposed to being adaptive, in that it is a mechanism that reduces the tension of psychological pain. As a result, he stated that the reasons for suicidal behavior make sense to the person engaged in the activity, and can be viewed as a value judgement about life (1993a).

Shneidman called for a shift in perspective from viewing suicidal behavior as a psychiatric disorder, a mental disease, to "a nervous dysfunction" (1993b). He identified the critical component of suicidal behavior as "psychache. . . the hurt, anguish, soreness, aching, psychological pain in the psyche, the mind" (p.145). The two major components of any suicidal behavior, posited by Shneidman, are perturbation and lethality. Perturbation, experienced subjectively and difficult to observe objectively, is the level of inner psychological distress, anguish and despair. Lethality is the extent to which the individual seriously considers the suicidal option as being the most tenable. Shneidman believed that individuals differ in their thresholds for handling deeply personal, psychological pain. His view of suicidal behavior helps to explain why one individual may be at high risk, whereas another is not: "The focus here is on thoughts, intentions, options, and choices, in the context of a very personal experience of the intolerable." (Kral, 1994).

Cognitive Dysfunction

The shift in emphasis from psychopathology to other explanatory factors led to the consideration of the possible role of cognitive factors,

including hopelessness ideation, problem solving strategies, and coping mechanisms (Hughes & Neimeyer, 1990; Kral, 1994). Beck, Kovacs and Weissman (1975) have associated suicidal behavior with depression, while the perception of hopelessness is viewed as a mediating variable. A hopeless attitude toward the future may dissuade an individual from generating, evaluating, or implementing solutions to their problems. In psychiatric patients, hopelessness is conceived of as a stable schema, incorporating negative expectations that are resistant to change.

Beck et al.'s (1975) theory hypothesized that individuals overwhelmed by hopelessness evaluate their world through a cognitive schema based on negative expectancy of effort. Negative outcomes are anticipated for all attempts to attain meaningful goals, resulting in hopelessness. In addition, the person holds a negative view of themselves, often judging themselves to be incompetent and inconsequential in all domains. Investigations of depression and hopelessness in suicidal children, adolescents, and adults have produced results indicating that hopelessness is often a more reliable measure of suicidal risk, including suicidal ideation and eventual suicide, than depression is (Beck, Steer, Beck & Newman, 1993).

Beck's (1986) research on hopelessness is used to confirm that suicide attempts are attributable to the individual's desire to escape from a situation or problem they perceive to be unsolvable. Beck has found that high levels of hopelessness are associated with motives such as escape whereas lower levels of hopelessness are related to parasuicides that are intended to generate change. Whereas Linehan (1986) and Schotte and Clum (1982) stated that hopelessness is positively related to the intensity of suicidal behavior, Beck, Steer, Kovacs, and Garrison (1985) reported that within an inpatient suicidal ideator population, the degree of hopelessness provides a more accurate predictive tool for indicating suicidal risk than the intensity of suicidal intent does. Criticisms of Beck's research result from studies being restricted to a chronic psychiatric population and being based upon the premise that suicidal behavior is rooted primarily in cognitive processes.

Connell and Meyer (1991) and Strosahl, Chiles, and Linehan (1992) conducted studies with college students and suicidal inpatients respectively. Each study reported that beyond the global pessimistic belief system characteristic of hopelessness, cognitions of suicide underwent revision as individuals moved closer to engaging in suicidal behavior. Both studies reported that suicide became the focus as a solution to the individual's psychological problems. They reported that beyond hopelessness, the individual's perception of their lack of ability to cope with the life problems, their lack of belief in the intrinsic value of life, and their lack of confidence in future improvement made major contributions to the decision to attempt suicide. Therefore, both studies concluded that other cognitive processes, in addition to hopelessness, play an important role in suicidal behavior.

Problem-Solving Ability and Coping Styles

The role of cognition is receiving increased research emphasis through investigations into problem-solving models and evaluations of coping skills. The problem solving theory of suicidal behavior suggests that inflexible problem solving contributes to suicidal ideation, attempts, and completions and studies have consistently linked the two (Hughes & Neimeyer, 1990). The underlying premise is that in high stress situations, a suicidal individual's ability to engage in divergent thinking is deficient to the extent that they are incapable of resolving life's problems satisfactorily (Mraz & Runco, 1994; Rudd, Rajab, & Dahm, 1994; Schotte & Clum, 1982).

Cognitive rigidity tends to be characterized by polarization of cognitive processes particularly concerning personally meaningful topics. It is manifest by either a tendency to view situations in extreme terms, at either ends of a spectrum with no gradation between (Hughes & Neimeyer, 1990) or the inability to appropriately identify problems and generate adequate solutions (Shneidman, 1985). Research has indicated that polarized attitudes are resistant to change and appear to contribute to poor quality interpersonal and intrapersonal interactions, which then contribute to a lack of social support. The negative experience may reinforce a negative self-

concept and/or world view which in turn exacerbates a perception of social alienation.

An investigation of university students (Mraz & Runco, 1994) suggested that the lack of flexibility in problem solving strategies led to increased suicidal ideation in reaction to the perception that the severity of personal problems outweighed the ability to generate adaptive solutions. Effective problem solving is therefore hypothesized to contribute to a reduced level of stress and to psychological health.

Schotte and Clum (1982) conducted a study with young adults and found that high stress levels were related to both hopelessness and depression, but reported that cognitive rigidity was not a factor that differentiated between suicidal ideators and non-ideators. They did report, however, that a high level of suicidal intent was related to cognitive rigidity when compounded by a number of negative life events that had occurred in the time just prior to the suicide attempt. They concluded that problem solving most likely plays a mediating role between suicidal ideation and intent.

Shneidman (1985) agreed that cognitive rigidity contributes to self-harm behaviors. In a clinical sample of suicidal ideators and attempters, Rudd, Rajab, and Dahm (1994) examined perceptions of problem solving ability within a diathesis-stress-hopelessness (D-S-M) model. Contrary to previously reported findings, they determined that life stressors did not play a critical role in either suicidal ideation or attempts, but that perceptions of problem-solving ability had a significant impact on levels of suicidal ideation and hopelessness.

The problem-solving model has been extended to include evaluations of coping styles. Coping styles are defined "as the cognitive and behavioral efforts used to master, tolerate and reduce demands that tax a person's resources" (Botsis, Soldatos, Liossi, Kokkevi, & Stefanis, 1994). Botsis et al. (1994) reported that suicidal inpatients produced exaggerated reactions to stressful situations and generally used coping options less frequently than non-suicidal patients. They concluded that "they (suicide attempters) probably have less inner energy and resources to deal with life

problems in an active and effective way". As such, the way the individual perceives and reacts to stressors may be more important than the stressor itself. These findings are consistent with those of other researchers in the field (Mraz & Runco, 1994; Ruddy, Rajab, & Dahm, 1994; Shneidman, 1985; Shneidman, 1989).

When suicidal individuals are asked to evaluate and compare their coping skills with those of individuals with whom they relate, self-ratings of adjustability and adaptability are extremely low relative to coping ability attributed to others. Interpersonal isolation may therefore result from viewing oneself as distinctly different from others (Hughes & Neimeyer, 1990). Additionally, studies have shown that as individuals fail to solve their problems effectively, their accumulated failures can lead them to view themselves and their life negatively. Once all alternatives for effective problem resolution have been exhausted, death becomes the most tenable option.

The Impact of Social Support

There are few who would argue that suicidal behavior is caused solely as a result of internal states without consideration of the contribution of the timing, severity, and frequency of external influences (Kral, 1994). This perspective has led to an increased emphasis on the social and interpersonal aspects of suicidal behaviors (Diekstra, 1989). Stressful life events have historically been tied to suicidal behavior, based upon the understanding that the impact of particular types of events may vary as a result of age, gender, and personality (Brent, Perper, Moritz, Baugher, Roth, Balach, & Schweers, 1993).

Heikkinen, Aro, and Lonnqvist, (1994) reported there is evidence that social networks are weaker for suicide attempters than for non-suicidal controls, but that research is limited on the role of social support or its absence in suicide. In the adolescent suicide literature, Mazza and Reynolds (1994) discussed the differential impact of social support and perception of social support as a function of gender. Whereas social support seemed to be

the best indicator of suicidal ideation one year after an attempt for females, the best predictor for males was negative life events and daily stress (Mazza & Reynolds, 1994). It is possible that social support systems may function as insulating or protecting factors against stressful life events for both genders. Commonly reported in both genders by younger age groups is a combination of social support themes which include conflict, separation, and rejection. (Brent et al., 1993; Heikkinen et al., 1993; Rich, Warsradt, Nemiroff, Fowler, & Young, 1991).

Interpersonal events, especially those that occur in the few weeks immediately preceding the suicidal behavior, have been commonly reported in the adolescent and young adult suicide and suicide attempt populations (Heikkinen, Aro, & Lonnqvist, 1994; Lester, 1991; Schotte & Clum, 1982). Events that occur within a six week period of the suicidal attempt appear to be critical (Brent et al., 1993; Heikkinen et al., 1994; Rich, 1988). Precipitating life events and other psychosocial stressors "provoke an outburst of suicidal intent" (Heikkinen et al., 1994, p. 344) particularly if they occur when the individual is vulnerable or lacking protective support. The research of Schotte and Clum (1982) indicated that suicide attempters report four times as many negative life events occurring within a six month period immediately preceding the suicide attempt than depressed or non-suicidal people do. Schotte and Clum (1982) suggested a model in which problem solving ability functions as a mediating variable when experienced in conjunction with negative life stressors, leading to hopelessness, then suicidal ideation, then suicidal behavior.

Rich et al., (1988) reported that people under the age of 30 appeared to be more sensitive to recent stressors than older people. This is reflected by far more young people reporting experiences of interpersonal loss or conflict within the previous six weeks, and particularly within a one week period of engaging in suicidal behavior. They concluded that over the life span, there are important developmental differences in the association between stressful life events and suicidal behavior. Interpersonal conflict appears to be one of the most frequently recurring stressors reported in the literature (Brent et al., 1993; Heikkinen et al., 1994; Lester, 1991; Rich, 1988;

Schotte & Clum, 1982).

Cognitive rigidity, problem-solving deficits and coping mechanisms are considered important variables in the life stressor research. Coping mechanisms are discussed within the framework of effective life adjustment and vulnerability to stressful life events. Deficient coping mechanisms were hypothesized to lead to a lack of emotional self-regulation, however Heikkinen et al. (1994) report that there are few studies that integrate vulnerability factors such as poor coping skills with recent life events. It is hypothesized that precipitating life events are often the impetus that move the individual from suicidal ideation to suicidal behavior. Perceptions of adverse life-events, however, can be based on real, threatened or imagined losses, and need not be observable to the outside world. Therefore, "It is obvious that simple tallying of presumably stressful life events (whether "negative" or "positive") is inadequate for comprehending their relationship to the cause of death." (Rich et al., 1988, p.591)

Life events can have both long term plus short term precipitating effects and are almost always conceived of as interpersonal loss or conflicts (Rich et al., 1988). The reported studies on life stressors, however, are based upon completed suicide populations and it is unclear how a population of suicide attempters may be similar or different.

Attributions of Motivation to Suicidal Behavior

Bancroft et al. (1979) and Hawton (1982) investigated reasons solicited from suicide attempters and compared them with reasons inferred and identified by mental health professionals for the same patients. Both studies determined that the reason most frequently expressed by the suicidal person was that the individual was trying to get relief from a terrible state of mind and did not know what else to do. The second most commonly generated reason was to escape from an impossible situation. Seeking help as a motivating factor was one of the least frequently chosen options in both studies. The authors conclude that individuals engage in suicidal behavior to alleviate their sense of personal/psychological distress.

In contrast to the suicidal individual's perceptions, attributions of motivation generated by caregivers differ significantly from patient self-reports. The caregivers included in the Bancroft et al. (1979) and Hawton (1982) studies tended to classify suicidal motivations as punitive and manipulative. Hendin's (1991) clinical experience tends to confirm these findings.

The results would appear to indicate the possibility that the caregivers or clinician may be misinterpreting the suicidal person's inner experience. A study by Eddin and Jones (1994) confirms this conclusion, adding that their results show that caregivers typically and consistently underrate the level of distress of their suicidal clients when compared to self-ratings. Whitehorn (1947; reprinted in 1994) calls for " the mutual understanding. . . by which physician and patient both come to understand the meaning of some of the patient's behavior in terms of the emotional need, rather than in terms of historical cause and effect" (p.199).

Attempted suicide has historically been viewed as a means of communication, often being characterized as "a cry for help " or "manipulative". Caregivers frequently consider the primary motive for the suicidal behavior to be an environmental change (Bancroft, Hawton, Simkin, Kingston, Cumming, & Whitwell, 1979; Eddins & Jobes, 1994; Gibbs, 1990; Nordstrom, Samuelsson, & Asberg, 1995; Schotte & Clum, 1982; Shneidman, 1985). However, manipulation is often viewed as pejorative, and this perception by others influences the interaction with the suicidal individual and the treatment they are offered. Caregivers perceptions of manipulative intent appear to discourage them from developing meaningful, helpful relationships with suicidal individuals, as the perception of manipulation creates hostility and lack of compassion (Bancroft et al., 1979; Carrigan, 1994; Eddin & Jones, 1994; Gibbs, 1990; Hendin, 1991; Shneidman, 1993a).

Hendin (1991) observed in his clinical practice that rather than experiencing hopelessness, his clients demonstrate 'despair'. "Desperation implies not only a sense of hopelessness about change but a sense that life is impossible without such a change." (p.1151) In addition, he indicated that

a common sentiment among suicidal young people is that they perceive themselves as failures relative to "their own and their families' academic, vocational, and social aspirations and [they] have fallen short of matching the achievements of their siblings and peers" (p. 1154). Therefore, added to failure is a sense of humiliation. Shneidman's (1985) research emphasizes that despair is a significant factor that leads to suicidal behavior.

Affective Components

Attempted suicide is often investigated by means of differentiating between high, medium, and low intent to die and is usually measured by scales such as the Suicidal Intent Scale (SIS) (Beck et al., 1974). The affective motivation for engaging in suicidal behavior appears to be different, particularly between the high and low intent groups, based upon the results produced by Hamdi, Amin, and Mattar (1991) and Mraz and Runco (1994). Hamdi et al. (1991) found affective components that differentiated the high from medium and low intent groups, but which could not distinguish between the latter two. The results indicate that underlying motivations, cognitions, and affective responses are dissimilar between groups. They also report that young adults score within the high intent group more frequently than adolescents.

Hamdi et al. argue that cognition and affect cannot be separated from subject's responses as they interact to direct the behavior of the individual as they more toward, and engage in, suicidal behavior. Hendin (1991) agrees, indicating that the affective state often provides the structure within which cognitive processes occur. In fact, it is often reported that attempters have contradictory or ambivalent emotions just prior to and during the suicide attempt. Although not specifically addressed, it would seem reasonable to assume that those with contradictory feelings may more likely be members of the medium and low intent groups.

Carrigan (1994) investigated the psychosocial needs identified by suicide attempters in a qualitative study focussed toward improving nursing care for parasuicidal patients. He reported that stressful major and minor life

events, in conjunction with low self-esteem and a need to be loved and wanted while at the same time feeling helpless and preoccupied with a sense of personal failure, were associated with each suicide attempt. Consistent with other studies (Shneidman, 1985), Carrigan reported that all respondents characterized their suicide attempt as an attempt to escape from a crisis situation and a cry for help. He concluded, "Parasuicide is not exclusively about dying, but also about survival and contact, its significance lies in the message it is intended to convey." (p. 639).

Carrigan's findings are consistent with those reported by Diekstra (1993). Diekstra, however, places additional emphasis on interpersonal interactions noting that these are characterized by conflict with the majority of the individual's social network and with negative views of relationships with others. These results are consistent with previously discussed research investigations of the impact of stressful life events. Diekstra identified individuals with a history of multiple suicide attempts as more likely to suffer from depressive disturbances, manifested through agitation, hostility, hopelessness, and feeling helpless.

Understanding motivational components of suicidal behavior may have important implications for both treatment and prevention (Hawton, Cole, O'Grady, & Osborn, 1982; Mazza & Reynolds, 1994). However, there have been few studies conducted to determine the motivational impetus of suicidal individuals from their own perspective, and even fewer studies conducted on the basis of spontaneous response as opposed to predetermined listings of possible motivations (Eddins & Jobes, 1994). Bancroft et al. (1979) found that suicide attempters produced spontaneous responses to motivational questions that included emotional responses to circumstances, and associated feelings concerning life or personal events. The Bancroft study indicated that these individuals often described their 'need to act' in response to life circumstances, however, when queried, they denied any manipulative motives or intentions.

Researchers have identified emotions common among individuals who engage in suicidal behavior (Hamdi et al. 1991; Hendin, 1991). Those that appear to be shared by most attempters were feelings of loss,

helplessness, inadequacy, self-hatred or self-depreciation, and guilt. Social isolation was a predominant factor in Hamdi and associates high intent group, whereas the medium and low intent groups were characterized by anger and frustration, states that indicate that attempting to change the environment may have been a primary motivational factor in their suicide attempts. Additionally a suicide attempt may be a "desperate attempt to maintain rather than sever the relation to the external world" (Hendin, 1991, p. 410). Stephens (1995) concurs that maintenance of contact with the world is often the driving force behind suicide attempts, particularly for women.

The seriousness of suicide attempts in late adolescents and young adults is often underplayed. Nordstrom et al. (1995) state "there is a tendency to underestimate the seriousness of a suicide attempt and the suicide risk particularly among young men" (p.338). They suggest that every suicide attempt should be taken seriously and that active and decisive case management should be implemented by caregivers when presented with such cases. This argument in based on data illustrating that in Sweden, 11 percent of those who attempt suicide go on to complete suicide within a few years. One possible explanation for this finding may be provided by the research of Goldney, Smith, Winefield, Tiggeman, and Winefield (1991). After an eight year longitudinal study with a cohort at the onset of the study aged 15 and 16, they found that suicidal ideation was not simply a transient phenomenon but that it was associated with pervasive, enduring, and entrenched personality characteristics. Relationships between suicidal ideation were produced with measures of self-esteem, depressive affect, and locus of control.

Developmental Literature

Young adults face developmental tasks specific to their transition from the world of adolescence to the responsibilities of being independent adults. Their challenges are different from those of other age groups in that for the first time, they must begin to accept full responsibility for their decisions about the present and future. There is typically less support during this stage

as peer groups alter and the nature of interactions changes. The individual struggles to develop a place for him or herself in an adult world as they look for appropriate career options and alternatives. They look to the outside world in a search for intimate relationships and finding a meaningful role in life (Erikson, 1978; Levinson, 1978).

Young adulthood requires the refinement of a sense of identity, particularly in relationship to others (Erikson, 1978; Leenaars, 1997). In order to successfully connect with others, each individual must develop an increasing ability to maintain intimacy and intimate relationships (Erikson, 1978). Relationships within the family generally change to accommodate more independence psychologically as well as emotionally. Changes in life style occur as the young adult lives independently or with peers rather than within the family unit. They separate from the family unit to become independent, yet related, individuals within society-at-large (Erikson, 1978).

Support networks outside the family become increasingly necessary as the search for intimacy and friendships extend outward into the community (Erikson, 1978; Heikkinen, Aro, & Lonnqvist, 1994; de Man, Leduc, & Labreche-Gauthier, 1993). While family support remains the primary network for some young adults, for many the family is displaced as the individual moves into the world in a new manner. New roles, and with them new expectations and rules of behavior, are being understood, evaluated, learned, and adopted.

Summary

Bland et al. (1994) and Sigurdson et al. (1994) stated that suicide attempters present a concern to both the medical and mental health professions in Canada because of the estimate that approximately 50% will re-attempt, often within a critical three month period following the initial attempt. Those who have attempted suicide but failed are at a higher lifetime risk of attempting again, often several times, until they are successful (Shneidman, 1985; Sigurdson et al., 1994). However, despite these statistics little is known about suicide and suicide attempters in Canada.

Sigurdson and his colleagues call for research to address this oversight.

There is much about suicidal behavior that we do not know. Based upon the literature reviewed, there appear to be some basic theoretical constructs that underlie suicidal behavior. These include: psychological pain, emotional distress, poor coping mechanisms, inappropriate reactions to external stressors, and depression. Historically, research methods utilized to examine suicidal behavior have necessitated a narrow focus on one dimension or variable to the exclusion of all others. It is increasingly clear that while this approach allows for specific data to be identified and examined precisely, it does little to encourage a holistic understanding of the phenomenon. The question "What does the suicide attempt mean to the individual who engages in it?" is seldom asked or answered. There are few available answers to the question "Why would an individual engage in suicidal behavior rather than choosing any number of other possible alternatives?".

Research questions

The gap in our understanding of the experiential components of suicidal behavior may be a result of a lack of research involving the primary source of the information. Investigating suicidal ideation and suicide attempts from the experiential point of view is an aspect of the human experience that has not been amenable to quantification, most often the method of choice in psychological research. A major concern is that the affective state of those feeling suicidal may result in unreliable and invalid information being provided by that individual. However, understanding the phenomenological experience of those most intimately involved is an area previously unexplored satisfactorily. A qualitative, descriptive method of study may provide access into some of the missing experiential and phenomenological components of this important social phenomenon allowing for this oversight to be addressed.

Examining the literature with the specific intent of understanding suicidal behavior in young adults proved to be a frustrating experience.

Research regarding the psychological development of young adults is scarce (Leenaars, 1997) and results must frequently be viewed with caution because of data being collapsed with that obtained from adolescents. Few studies differentiate between adolescents and young adults. Discussions of "youth suicide" could be based upon a sample of 13 to 18 year olds, or just as easily include 15 to 24 year olds. Seldom are developmental issues addressed, nor is the suicidal behavior researched from a developmental or life span perspective. Because of these and other deficiencies in research methods, many results must be viewed with skepticism or shed little understanding to young adults as a specific population at risk for suicidal behavior. Leenaars (1997) clearly identifies young adults as a population sorely neglected in the research of this most important social issue and calls for studies to address this deficiency.

The preceding review and critique of the research helps to formulate the rationale for a study which informs itself from the perspective of those who have engaged in suicidal behavior in an attempt to better understand the subtleties and complexities of the powerful interactions that contributed to the decision to end life. The questions that were investigated in this study include:

- What was the psychological reality of suicidal individuals prior to their decision to commit suicide?
- What psychological needs were identified as contributing to and affecting the decision to attempt to take their own lives?
- What were the individuals perceptions of the environmental factors that contributed to the decision to engage in the suicidal behavior?
- What personal factors were understood to have contributed to their decision and how did they impact the decision making process?

These questions move from the general recollection and description of experience to one of interest to those who deal with suicidal issues through either research or clinical interactions. Because the primary interest of this study is to understand the experience of young adult suicide

attempters, a qualitative research design was chosen as the most appropriate method of investigation.

The following chapter provides a rationale for the use of the qualitative approach for this particular study. The methodology of a study defines the procedures used in answering the research questions posed. Therefore methods of data collection and data analysis are described in the following section.

Chapter Three

Methodological Considerations and Decisions

As noted in the literature review, the primary method of investigation of both suicidal theory and treatment is the natural science or quantitative research method, which focusses on identifying and clarifying specific, identifiable relationships. It is based on objectivity and a concrete measurement of the phenomenon. The intent of natural science is to seek explanation and to predict outcomes. Rather than investigating a phenomenon experientially, the quantitative method requires that the researcher's focus be clearly defined with very specific questions that are measurable, observable, and replicable. Phenomenon are not investigated experientially as personal narratives are considered to be lacking in objectivity.

The qualitative, human science approach is based upon the philosophy that understanding is obtained by direct interaction with those individuals who have experienced the phenomenon of interest, allowing insight into their personal perspectives (Van Manen, 1990). The goal of this research approach is understanding through the use of description rather than exploratory science (Osborne, 1990). In order to understand what it means to be human, one must consider the notion of coconstitutionality; that the person and world constitute an interdependent unity. Such a philosophical basis allows the researcher to simultaneously focus on the internal feelings, thoughts, and reactions of each participant while also considering the interaction with environmental conditions that contributed to the phenomenon being investigated.

Rationale for qualitative research

Understanding the experience of a suicide attempt requires a method and perspective that investigates the experience of the participants that

must be both revealed and interpreted. "The social sciences are concerned with humans and their relations with themselves and their environments, and as such, the social sciences are founded on the study of experience" (Clandinin & Connelly, 1994, p. 414). Phenomenological investigations are specifically designed and suited to studies in which there is an attempt to elucidate the meaning of an experience and the researchers are concerned with the person as a participant rather than an object. The main assumption of phenomenology is that experience is grounded in existence.

The phenomenon of suicidal behavior is both multifaceted and multidimensional, eliminating the possibility of simplistic answers to many of the relevant questions in the field. "Suicide is best discussed (and studied and practiced) in terms of mental concepts like pain, anguish, and threshold for suffering -- rather than in terms of synapses, MAO inhibitors, bipolar depressions, and neurotransmitters, or any other reductionistic physical language. We must stay with the phenomenology of the event." (Shneidman, 1993, p. 292). The qualitative method allows for the emergence of the situation, the behavior, and the experience of the participant, to be illuminated from the insider's point of view. As such, the researcher is open to the rich nature and range of possibilities in each life story. The qualitative method enhances the researcher's ability to follow leads in directions appropriate to each participant's experience.

Methodological Concerns

Third party information is often criticized as being unreliable because of lack of intimate insight into the suicidal persons actual state of mind. Additionally, when dealing with the emotionally laden issue of suicide, the family and friends of those that suicide may experience difficulty dealing with their own issues surrounding the suicide of a loved one which might cloud their understanding of the suicidal person's experience. Many are unaware of the nature of the struggle experienced by the suicidal individual. The nature of participants, research questions, generation of data, reflective analysis, and theory development each have a direct influence in advancing

differing methodologies in qualitative investigation.

The questions posed in this research project required a method that focussed on discovery and understanding rather than a natural science method of deriving cause and effect relationships. The goal was to understand the meaning of the actions and experiences leading up to the suicidal behavior from the insider perspective. Qualitative methods consider phenomenon as being available to discovery through dialogue, a discourse that is believed to reflect a persons experience as a synthesis of their internal and external worlds (Colaizzi, 1978). To achieve the objective, the phenomenological method of data analysis was chosen as the most appropriate method which explores a phenomenon from the insider perspective. Phenomena are captured in experience, which is comprised of the outside world and the individual's perception or understanding of that world. Phenomenology was chosen to descriptively identify the experience of suicidal behavior in order to more fully discover and understand the phenomenon.

The phenomenological approach facilitated the exploration of each participant's affective and cognitive world views which interacted intimately to structure their individual experiences. The nature of the suicidal experience for young adults was examined by subjectively contextualizing aspects of their culture, language, and life experiences. Adopting this method was intended to increase understanding within a descriptive and interpretive approach and was an effective way of capturing the meaning of the experiences.

The nature of the data obtained was based upon the experiences expressed by the participants of this study, whether past, present or anticipated in the future. The data from each participant was recorded and transcribed as text. The nature of the analysis to which it was subject was both descriptive and interpretive. In order to ensure that it was the participant's voice being heard and presented, a qualitative method of analysis has been adhered to in order to address the trustworthiness of the phenomenological method of inquiry.

Rationale for Interview Method

Data was obtained through direct interviews with volunteer participants who had made suicide attempts within the specified age range. The advantage of relying upon personal interviews is that the uncertainty and bias introduced by obtaining information from third party informants, the method most commonly used in psychological autopsies of suicides, is eliminated.

Life events and their interpretation occur within the psychological framework of the individual. There is usually a complex connection between life events and their psychological meanings to the individual. Some events may play a critical role in the suicidal process of some individuals whereas they do not for other individuals who share similar experiences. Direct interviews allow for the exploration of important personal events, the extent to which they influence the participants perceptions and cognitions, attributions of meaning, and the affective responses that result. Both intimate experience and the cumulative effects of the individual's life can be explored in a direct interview.

Sampling

Because of the nature of the phenomenon being investigated and the population the investigation entailed, sampling for this study was not random, but rather purposive, otherwise known as criterion based selection. This method is described by Morse (1989) as "selecting the best informant who is able to meet the informational needs of the study. . . and selecting a 'good informant' . . one who is articulate, reflective, and willing to share with the interviewer" (p. 117). This is accomplished by including participants who have first hand experience with the phenomenon; deciding to attempt, and attempting suicide.

Purposive sampling is meant to be neither representative of the population at large nor typical. Rather, this method of sampling allows for

maximizing the range of information covered and does not require that understanding of a particular experience be generalizable to all cases. As a result there are no criteria that needed to be identified in advance for locating and selecting the research participants other than their experience with the phenomenon being investigated (Moustakas, 1994). There were however, general considerations such as age, gender, race, religion, cultural and ethnic factors that impacted on the selection of research participants.

The essential criteria for inclusion in the study included: (1) first hand experience with the phenomenon under investigation; (2) an ability to articulate their experience and a willingness to share information that is intensely personal, private and sensitive; (3) an interest in understanding the nature and meaning of the experience to the best of their ability; (4) a willingness to share their experience by participating in a lengthy interview process, followed by further interviews for clarification; and (5) consent to allow the interviewer permission to tape-record the interview and utilize the data in the publication of a dissertation or other publications and presentations.

Selection of Participants

The criteria for selection of participants were as follows:

- Both male and female participants are included.
- Participants must have made only one suicide attempt while between the ages of 20 to 24.
- The attempt must have occurred within the past five years.
- Participants will have considered themselves non-suicidal for a minimum of 6 months.
- The participants must have been willing to discuss their perceptions and perspectives, able to articulate their experiences clearly, and fluent in speaking and understanding English.
- They were solicited from both urban or rural locations.

The individuals who chose to participate were obtained through advertisements placed in the classified section of local and rural newspapers within the designated geographical parameters, from personal presentations about the nature and purpose of the research made by the researcher, and from public service announcements made on radio and television stations that asked for volunteers. Interested individuals contacted the researcher directly by telephone, and a short telephone interview was conducted to determine whether they fit within the criteria for inclusion of the study. The purpose and intent of the research project was described to each individual who expressed interest in participating. Once a determination was made that the volunteer was an appropriate candidate, the nature of their involvement and time requirements was discussed with each volunteer. Once obtaining this information, some volunteers declined participation.

A written proposal describing the nature and purpose of the study was prepared and a copy given to each of the respondents on the first meeting. From the interview and discussion of the nature and purpose of the study, the researcher determined whether the volunteer was an appropriate participant for the investigation. Volunteers with a history of numerous suicide attempts during childhood, adolescence, and young adulthood were eliminated from the sample because of concern about the possible difference between a multiple attempt population and a population in which suicide attempt was not a frequently chosen alternative. Several appropriate volunteers declined participation once they became familiar with the research method and purpose of the study.

During both the initial telephone interview and the first taped interview, each participant was informed that all personal and identifying data, including identifying features of personal history and name, would be removed from all written material or presentations that resulted from the research. In addition, each was informed that participation was strictly voluntary and that they had the right to withdraw from the study at any time, for any reason. After all volunteer questions had been answered to their satisfaction a Consent to Participate form was signed (See Appendix B).

Participants were then given the option of proceeding with the interview immediately or arranging an alternate time to conduct the interview. All chose to continue with the interview immediately.

Five participants were included in this study, four were female and one male. They ranged in age from 24 to 27 at the time of the interviews and had attempted suicide between the ages of 21 to 25. At the time of the initial interview, one participant was married, one had a child, and another was pregnant; three were single and not involved in long-term relationships. Three participants lived alone, and two lived with a partner. Two participants held full time jobs, two worked primarily within the home; one was completing an undergraduate degree and two worked part time. Four had attempted suicide between the ages of 10 to 15 and one had made no attempt prior to early adulthood.

Interview procedure

An interview was conducted with those who expressed interest in participating in the study. At the outset, the participant was oriented to the nature and purpose of the research. Issues regarding the voluntary nature of the study, confidentiality, informed consent and withdrawal of participation were clearly outlined. Any questions the potential participant had regarding the nature of the proposed study were answered at this time. Written permission was obtained when the interviewee agreed to participate. The participant's signature was taken as informed consent.

Several opening statements to begin the interviews had been formulated prior to the initial meetings with participants. In addition to providing a standard way to begin each interview, these statements were designed to facilitate an open and honest dialogue with the participant. The data-gathering portion of the interview followed a broad and unstructured format which allowed the participant to describe their experience with minimal input or direction from the researcher. The participant was encouraged to describe, as fully as possible, their own experience using their own language. Open-ended, non judgmental questions were

presented (See Appendix C - General Interview Guide) and active listening techniques of paraphrasing and reiteration were utilized to clarify issues or statements. These techniques, in addition to promoting self-disclosure by the participant, increased the researcher's ability to communicate and obtain an understanding of the participant's experience.

In order to obtain the most information, it was important to develop a significant rapport between the researcher and the participant to foster an atmosphere and perception of acceptance and to guarantee the safety of the participants prior to a meaningful disclosure taking place. Only after the participant has spoken freely of their experience, and when specific issues of interest to the researcher were not addressed spontaneously, were probes or specific questions presented by the researcher. In this way, rigor was subject oriented rather than experimenter defined (Stevick, 1971). Each interview took approximately two hours, was audio taped and transcribed.

Following the completed analysis of interview data and production of a written synthesis by the researcher, a follow-up interview was conducted with four of the participants. This procedure allowed the participant to determine whether the analysis of the data gathering was an accurate and valid interpretation of their experience. It also allowed them the opportunity to clarify any misunderstandings or misinterpretations made by the researcher. While these interviews were not audio taped as the initial interviews had been, notes were taken and new information presented or corrections required were incorporated into the data.

Analysis and interpretation of data

Qualitative research is concerned with providing contextual information, enhancing meanings and purposes attached by individuals to their behaviors, therefore it can provide rich insight into human behavior (Osborne, 1990). Qualitative methods are concerned with enhancing the insight of meanings, concepts, and descriptions of things from the insider's perspective. Analysis and interpretation of qualitative data differs from that of quantitative research. Quantitative research aims to verify or falsify a priori

hypotheses, most often attempting to identify functional relationships with increasing precision. Utilizing the 'objective' or outsider perspective, the primary goal is to enhance both prediction and control of natural phenomena (Guba & Lincoln, 1994; Osborne, 1994).

Because of the focus on understanding meaning, every attempt was made to allow the data to speak for themselves. Data analysis procedures outlined by Colaizzi (1978) were implemented. Transcribed interviews were read and re-read to allow the researcher to become familiar with the life world of the participant. The relevance of each statement and its association with the suicidal process was thoughtfully evaluated and analyzed individually for meaning. Significant statements, phrases, sentences, and paragraphs were extracted and recorded in a tabular manner. Paraphrases generated in an attempt to clarify underlying meaning were recorded for each statement. Themes were identified, then statements were clustered based upon common themes. Clusters that fit together to clarify the most fundamental, the essential meaning, or in the words of phenomenologists, the immanent meaning of each protocol were generated in an attempt to define the nature and structure of the phenomenon (Colaizzi,1978). A written synthesis of each protocol was generated. Each protocol was analyzed independently and represented a within-person analysis.

After the within-person analysis was complete, a between-person analysis was conducted in order to allow the emergence and identification of themes that were common to all protocols. Each protocol analysis was reviewed with the intent of eliminating irrelevant descriptions and unnecessary repetitions. The remaining clustered themes were pooled between protocols. Clusters were compared to each protocol to determine whether any themes were overlooked, and to highlight the unique features or themes that were not included by the clusters. The underlying meaning was obtained through the clusters, and a description of the phenomenon was written.

Second-order themes produced by clustering were compared to significant statements in the original protocols in order to validate the meaning of the themes, the clustering of the primary themes, and the

clustering of the higher order themes. Careful reflection followed in order to determine whether each protocol exemplified the thematic structure of the second order themes. The thematic structure was refined and abstracted to illustrate the experiences within the descriptive data. Unique features were observed, noted, and incorporated within the refinement process to emphasize the cognitive and affective meanings that each individual experienced during their suicidal reality.

The written synthesis was validated by discussion with the participant in the second interview that focused on determining the accuracy of the researchers understanding and interpretation of the data. Clarifications and inaccuracies were discussed at this time. The participant was also given the opportunity to present any additional information they considered relevant but may have overlooked in the data gathering interview.

Validity and Reliability

The major ways in which validity and reliability are addressed in qualitative research methods include bracketing, descriptive validity, interpretive validity, and theoretical validity (Maxwell, 1992; Van Manen, 1990). Descriptions of methods used to produce validity and reliability of this study follow.

Bracketing

Close and careful inspection of the researcher's own personal perspectives and understandings of a phenomenon is the essential nature of bracketing. Bracketing was undertaken to clearly delineate and articulate the researcher's predispositions and biases through rigorous self-reflection and to separate the researcher's beliefs and thoughts from those of the participants. As much as possible, all aspects were closely examined and scrutinized. Careful reflection and thought allowed the researcher to unmask, define, and determine the basic elements and essential structures of the phenomenon (Berg, 1995). Self-awareness increased the

researcher's ability to set aside personal prejudices.

Increased awareness through bracketing allowed for biases that may have affected the interpretation to be identified and monitored throughout the data collection and data analysis processes. This reduced the risk of projecting bias onto the interpretation of the participant's experiences. Suspending my own judgment allowed me to accept the reality of the situation from the participants' point of view, as it is their perception of the events rather than the actual events themselves, that is important. Setting bias and predispositions aside makes the understanding of other perspectives possible. Ultimately a new perspective is generated (Van Manen, 1990).

Bracketing helped to enhance my awareness of my own interpretive framework. In addition, it was important to accurately reflect the experiences as revealed by the reflections of the research participants. As the answers to the research question for this study unfolded, I began to recall my own experiences of being part of the world, changing perceptions of control, successes and failures, changing needs and desires, and the search to understand how life fits together into a comprehensive whole. I reflected on my own socialization processes, understanding of the world, personal relationships, educational experiences of success and failure, and the various paths chosen in life. A personal journal was kept throughout all the phases of the research project to record thoughts, feelings, and ideas that required further thought or discussion with colleagues.

Descriptive Validity

Descriptive validity refers to the factual accuracy of the accounts obtained from each participant. Interpretive and theoretical validity are dependent upon the accuracy of the researchers' reports of the data given to them by the participants (Maxwell, 1992). One of the major threats to descriptive validity is the omission of aspects of the phenomenon that are significant to the account from the participants point of view. In order to address this issue, triangulation, the procedure of obtaining confirming data

from a number of perspectives or within the participants account of events, is often utilized. Because only single sources of information were available in this study, the triangulation method used involved evaluating the consistency within each participants' presentation of their experiences.

Interpretive Validity

Interpretive validity refers to the concept that the account is accurate from the perspective of the individual being described (Maxwell, 1992). The meaning must be based within the conceptual framework of the participants involved, relying on the participants' own words and understandings. Interpretive validity is accomplished through bracketing, an audit trail, and communication with the participant. Bracketing is the process in which the researcher clearly describes, prior to and throughout the data collection process and analysis, his or her presuppositions that, if not addressed, may bias the interpretation of the data. The audit trail is a clear and detailed description of the procedures of data collection and analysis. It allows the reader to understand the researcher's process which enables the reader to understand how the researcher arrived at their interpretation. Communication with the participant is the last step in establishing interpretative validity. The researcher's interpretations were taken back to each participant to confirm accuracy and validity who were encouraged to make corrections and clarifications as needed.

Theoretical Validity

Theoretical validity involves more than concrete description and interpretations and includes addressing the researcher's theoretical understanding of the account as an explanation of the phenomenon (Maxwell, 1992). The validity of both postulated concepts and the relationships between those concepts must be examined within the context of data obtained in this study. The obtained data were critically evaluated to determine how they fit with the current theoretical perspectives about

suicidal behavior. Alternative explanations and interpretations are addressed in Chapter 6.

External Validity

The term transferability is generally used in qualitative research methods to define issues of generalizability (Denzin & Lincoln, 1994). Empathic generalizability relates to the goodness of fit between the reader's and researcher's interpretations, in which the reader determines whether the interpretations are reflective of their own experiences of the phenomenon. In an attempt to explore a phenomenon in depth, the sample size is restricted to a small number in qualitative research and no attempt is made to generalize to a large population. Instead, the reader is left to determine whether meaningful connections can be made between the research findings presented through rich and deep description and commonalities with their own experience.

Reliability

Reliability is obtained when different observers or methods produce descriptively similar accounts of the same events (Maxwell, 1992). While Denzin and Lincoln (1994) describe reliability in qualitative research as dependability, Osborne (1990) refers to it as consistency, replicability, and stability of measurement. Consistency and replicability are determined by the fit between what is recorded as data and what actually occurs in the setting being studied, not across observations. In this study, the same format, interview guidelines, and procedures were used for all participants in the data collection and data analysis phases.

Varying accounts obtained because of differences in perspective are not a threat to reliability, as both can be descriptively valid given the theoretical perspective. Reliability was ensured when the researcher clearly outlined the method by which the data were analyzed, provided examples and segments of each transcript, and presented interpreted segments after

conferring with the participant.

Ethical Considerations

This research project followed standard ethical guidelines in that informed consent was obtained from each participant and participation was strictly voluntary. Each participant was informed both verbally and in written form that they had the right to withdraw from the study at any time, and issues of confidentiality were addressed in that identifying information has been altered and pseudonyms are used in all publications and presentations that result from this study.

In accordance with the standards of the University of Alberta, before the study is undertaken, a detailed proposal was submitted to the Department of Educational Psychology Ethics Review Committee to obtain approval for the proposed research procedures. Following the written notification of committee approval of the proposal and procedures, a preliminary interview was conducted with potential participants to determine their eligibility, interest, and willingness to participate. Each received a covering letter comprised of a clear summary description and explanation of the purpose of the study. (See Appendix A, Purpose Of This Study) The form provided an explanation of what their participation entailed, a restatement that participation is voluntary, and that they had the right to withdraw from participation at any time. Assurances that all information that could identify them would be kept strictly confidential was included. In order to guarantee anonymity for the participants, pseudonyms were used, and slight alternations were made in irrelevant personal detail.

Willing participants signed a consent form indicating that they understood the nature and purpose of the study, that all relevant questions regarding the research had been answered by the researcher, and that they were willing to participate. Signed consent forms were filed separately from the data in order to maintain and ensure the anonymity of the participants. (See Appendix B for the Consent to Participate form).

All interviews were tape recorded in order to insure accurate

interpretation of the participants responses. Tapes were kept in a secure location, until such time that they will be destroyed or returned to each participant, dependent upon the participant's stated preference.

The intensive interaction between researcher and participant requires special attention to ethical considerations in phenomenological research (Clandinin & Connelly, 1994). Given the personal nature of the experience being investigated and the potentially intensive interaction between researcher and participant, there was the possibility that issues could be raised that were disturbing to the participant. During the interview process, it is mandatory to remain sensitive to the possibility that the participant may have been experiencing personal discomfort or difficulty in recounting their experience. When issues of concern arose with which the participant requested assistance, they were directed to available counselling resources accessible in their area.

One of the results of this type of research process is that in retelling an experience, the participant often gains insights or reflects on issues from a different perspective. The reflections sometimes require more in depth counselling. When issues arose through the course of the interview that the participant felt the need to deal with, appropriate counselling support was provided as required.

Limitations

The purpose of this research project was to explore the meaning of suicide attempts for the young adults who participated. The qualitative method chosen, namely phenomenologically, focussed the researcher on exploring personal experience as lived. Phenomenological studies are concerned with what constitutes a particular experience (Polkinghorne, 1989), specifically, the personal realities that led each participant to attempt to end their life.

To understand the meaning of the experience for these individuals, the study could only be conducted retrospectively (van Manen, 1990). While the length of time between the experience and the telling may have resulted

in some reduction of accuracy of events or time frame within which the events occurred, the fundamental meaning of the experience can be retained. There is also the possibility that perceptions of the suicide attempt may have become distorted as a result of environmental changes that resulted from the suicidal activity.

This study was limited by the descriptive account of the participants who each attempted suicide between the ages of 20 to 24. The experiences of people in other age groups may or may not be different. Additionally, in consideration of the small number of participants, it is not the intent to generalize these results to those who did not participate but may experience similar life events.

The interpretations given to the data are anchored in my own assumptions and understanding about life and its inherent value. The interpretations are also restricted by my interpretive abilities as well as by the extent to which each participant addressed issues important to them and articulated their perceptions with clarity and accuracy. Exploring avenues of interest or relevance was restricted by the necessity to restrict the length of discussion with each individual to what was thought to be reasonable. It has been my intent to remain as close to the data as possible and to accurately describe and understand each participant's suicidal experience. It is likely that future studies with similar texts will vary and disclose yet another side of the experience of being suicidal.

Delimitations

The age range within which participants were chosen was restricted to include only those who had engaged in suicidal behavior between the ages of 20 to 24, and who were below the age of 29 at the time of the study. Each interview was restricted to a two hour time period as it was determined that this allowed an appropriate amount of time to explore the life experience of the participant and did not require too large a time commitment from them. Data were gathered utilizing a semi-structured interview process that allowed the participant to disclose their experiences in whatever

chronological format they felt was appropriate. The participants were used as the sole source from which data was obtained as the intent of the study was to explore the meaning and reality of the suicidal experience for each participant. Although individual stories were not verified by third party observers of the suicidal individual, the information provided by the research participant was triangulated with the suicidal literature that was reviewed by the researcher.

Chapter Four

INTRODUCTION TO PARTICIPANTS

Five participants who were willing to share their experience of attempting suicide while in their early adulthood were interviewed. The interviews were used as a method of developing a conversation with each participant to understand the life experience that lead them to make and implement the decision to end their life. In asking about the experience for each individual it was important to be concrete as well as to understand the path they found themselves following. At the beginning of each interview, I asked each participant to begin their story at whatever place in their life they thought was the most appropriate beginning. It was not possible nor advantageous in the interview to create predetermined questions or to report the results in the form of answers to specific questions. Each interview was audio-taped and transcribed. The texts created became the basis for phenomenological reflection and analysis. The purpose of the phenomenological method is to grasp the meaning of the experience through reflection.

The method that I used to uncover, reveal, and identify the thematic aspects of the phenomenon of suicidal behavior involved several steps. At the onset of undertaking the analysis, I listened to the audio tapes and read my field notes, then I listened to the tapes of each interview while reading the text. I tried to capture and identify the fundamental meaning of the text as a whole. The texts were then reread and important statements or phrases were highlighted that seemed to capture the meaning of the experience of the phenomenon for the participant. The text was then reviewed to determine if each sentence developed the specific concept identified earlier.

It was helpful to compose brief biographies of each of the

participants. These descriptions gave some sense of time, space, place and the structure to the story as it unfolded. Biographies were presented to the participants and they were invited to edit them to ensure accuracy. Described on the following pages are the participants' stories. Pseudonyms of Debbie, Elaine, Lisa, Janet, and Ryan were assigned to protect their identities. Where necessary, some personal details have been slightly altered to further protect their privacy.

DEBBIE

Debbie is a 27 year old married woman with one child. She is born and raised in a mid-sized Western Canadian city. Debbie was the youngest of several children who lived with both parents. Her family was heavily involved in the artistic community and a family business. Both her father and an older sibling were diagnosed with manic depression and received intensive medical care for as long as she could remember. Her father was hospitalized on a number of occasions for manic and depressive episodes. She described the home atmosphere as emotionally abusive. She was particularly upset by the way her ill sibling, who had returned home after experiencing a severe episode of depression, treated her. Despite her emotional response, Debbie continued to describe her family as being close knit and dependent upon one another.

At two points in her life, when she was aged 6 and then seven years later, Debbie's brother became involved with her sexually. By the age of 14, Debbie was experiencing difficulty in school, with her peers, and in her family life which was becoming increasingly difficult to deal with. She began to experience symptoms of depression and to emotionally withdraw from social situations with peers. She missed school regularly and lost interest in activities that had previously been enjoyable.

Debbie attempted suicide at the age of 14 by ingesting a large

number of sleeping pills that were available in her home. She characterized this action as impulsive in that the decision to attempt to take her life was made quickly. She had been feeling depressed for an extended period of time; however, she was unable to recall any specific triggering event prior to her suicide attempt. After ingesting the drugs, Debbie phoned a friend of the same age and confessed that she had taken the medication. No action, however, was taken to intervene to save her life. Upon discovery of the missing medication, Debbie was punished by her mother for abusing prescription drugs, but the motivation behind her behavior was not explored, investigated, or discussed.

Debbie began seeing a psychiatrist at the age of 15 at which time she was diagnosed with clinical depression. In addition to prescribing antidepressants, the psychiatrist felt that removal from the home would be helpful. Therefore Debbie moved to the home of a friend where she continued to live until she finished her schooling. Although Debbie finished most high school courses, she did not graduate with a diploma.

From the age of 15, Debbie began to use both prescription and illegal drugs and alcohol heavily. In her early teens, prescription drugs were readily available in her parents home, and she frequently stole from her parents' supplies. Taking the drugs temporarily made her feel better and helped her forget her emotional distress. In addition, she had access to illegal drugs through her siblings who were also heavily involved in illegal drug use. Alcohol was readily available both within the home and from outside sources.

Debbie's dependence on drugs and alcohol increased as she grew older. At the age of 22, she experienced severe depressive symptoms but was not able to alleviate them through self-medication as she had done previously. She began to engage in self-mutilative behaviors such as cutting her wrists and hurting herself in other ways. Her memories of the incestuous relationship with her brother became increasingly difficult to deal with, and she began to struggle with ways in which she could deal with the problem without hurting family members, particularly her mother. She felt that the pressure of dealing with the

incest was more than she was capable of handling. However, she felt extremely guilty when she contemplated disclosing the incidents in an attempt to get help because of the risk that it posed to interactions with family members. Debbie felt as if she was trapped. She felt that to disclose the incest would destroy the family. To not disclose the incest was to destroy herself.

Debbie attempted to take her life at the age of 22 after a night of heavy drinking. She went to her parents home where she knew that she could access a large number and variety of medications and took all that she could find. After some time passed, she phoned a friend in another city. The friend then contacted family members who intervened. Debbie was hospitalized and later sent to a detoxification unit for a five day period, diagnosed as a drug addict. She continued to receive medical attention after her discharge but went back to drug and alcohol use after a short period of abstinence.

Debbie met a man, married, and has since had a child. She works part time but is primarily a stay-at-home mother. She continues to engage in mutilative and self-destructive behaviors and has undergone both group and individual therapy to address the issues of sexual abuse with her brother. She continues to suffer from depression; however, she is becoming increasingly effective at dealing with the episodes before they become excessively problematic. She hopes to have another child sometime in the future.

ELAINE

Elaine is a 25 year old recovering alcoholic. She is the eldest of three children and lived in a small town in eastern Canada until her middle school years when the family moved to a small town in western Canada. Elaine's parents divorced when she was 10, and her mother moved the family to a number of locations before settling in a city. Elaine remembers her childhood, before the divorce, as being happy, healthy, and secure.

After the divorce, Elaine lost contact with her father who by then

had become heavily involved in drugs and alcohol. In addition, Elaine felt that she and her siblings played a secondary role in the life of their mother who was more focussed on establishing and maintaining a relationship with the new man in her life. Although contact was briefly reestablished with her natural father, he proved to be an unreliable parent, often forgetting to pick up the children for the weekend or leaving them unattended when they were in his custody. Elaine lost contact with her father after Grade 9 and did not see him for eight years.

Shortly after the divorce, Elaine's mother met a man with whom she became involved. He had one child. It was at this time that she and her family moved to the city. The two families moved into a single household and into a lifestyle with which Elaine was unfamiliar and uncomfortable because of newly imposed rules of behavior and standards of conduct. She and her brothers found that their behavior and their use of the home was restricted and highly scrutinized. Prior to the move, they had experienced few restrictions in activities and house rules. In addition, Elaine felt more at home in the country setting than in the city.

Elaine began experiencing difficulty in school after her move from eastern Canada and felt that she had been treated badly by school staff and teachers until she reached high school. She did not engage in extracurricular activities during her school career. She considered herself to be different from other children and did not have an established peer group with whom she interacted until her high school years.

Elaine made a suicide attempt at the age of 13 when she became extremely angry and upset about her life. She described this event as impulsive and motivated by her anger. Rather than receiving help upon discovery, Elaine was punished by her mother for the attempt. Her reasons for attempting to take her life were not dealt with either within the family or through outside assistance.

At the age of 15, Elaine was involved in a sexual encounter with her stepfather when her mother was out of town. She was extremely distressed by this event and hated her stepfather even more that she had previously. However she did not disclose the incident to anyone until she

was 21. Her relationship with her mother had deteriorated to such an extent that Elaine ran away from home at the age of 16 and became involved in a relationship with a man twice her age. She characterized the relationship as emotionally and physically abusive. Despite her lifestyle and heavy involvement in drugs during this period, she was able to maintain her attendance to, and graduate from, high school. The relationship with the older man ended when she was 18 and she began working in a bar as a waitress at which time Elaine began drinking heavily.

Elaine moved from one unhappy sexual relationship to another and her drinking became more and more problematic. At the age of 21, Elaine decided that she required assistance in dealing with the issues in her life and with a depression that played a large role in her ability to function effectively. When she was prescribed antidepressants Elaine lied to her doctor by denying that she had a drinking problem or that she drank regularly. As a result, the medication was less effective than anticipated. After seeking therapeutic assistance, Elaine disclosed the sexual encounter with her stepfather and was encouraged to disclose this information to her mother to assist in the healing process. Although she did not feel emotionally prepared to deal with her mother's responses, Elaine wrote and sent a letter. When no support was initially forthcoming from her mother, Elaine found the lack of response very distressing.

The relationship between her mother and stepfather ended temporarily; however, they were able to reconcile after a promise that the stepfather would obtain counselling and the family would work on changing the relationship. Neither the mother or stepfather followed through on the agreement, and their family life returned to the status quo. Elaine felt betrayed by her mother as they had been attempting to develop a relationship since the disclosure. However after the couples' reconciliation Elaine felt that her mother had rejected her and her pain.

On her 22nd birthday, Elaine attempted suicide by slashing her wrists while drunk and having taken an overdose of antidepressants

mixed with other available medication. After having convulsions and vomiting repeatedly, she phoned her mother to take her to the hospital.

On her return home, Elaine contacted Alcoholics Anonymous under pressure from her mother about her drinking problem. She has been sober since that time and has begun to develop a healthy and solid relationship with her mother based on trust and honesty. Elaine has been involved in a relationship for over two years and was expecting her first child at the time of the interview. She and her partner had decided that she would remain home to raise their child, and they were actively involved in creating a healthy home atmosphere for their future family. Elaine has made a series of choices in the reconstruction of her life, that others might describe as "gutsy" but which she views as "only necessary".

JANET

Janet is a 24 year old, unmarried woman who was attending a diploma program at a college in a mid-sized Canadian city. She was close to finishing her program at the time of the interview and had plans to move to eastern Canada with her parents and siblings. Janet was the second of four children but had a different father from her older and younger siblings. After her parents divorced, when she was five, Janet and her older brother were separated, one living with each parent. Her mother remarried and the family moved to new city within a one year timeframe. Janet stated that she never liked her new stepfather and that she always felt alienated from her half brothers. Janet had no contact with her natural father or with her older half brother for several years. She frequently felt that she was treated as if her mother hated her. She wondered why, and during childhood became convinced that the reason was because she was another man's child.

Janet was a good student throughout her school years, performing at the top of her class in each grade with the exception of grade two. She stated that she was retained for a second year having a negative emotional response to the family break up. During her school years, she was actively involved in a variety of sports and artistic endeavours. Both

provided her with a sense of accomplishment and personal value. The family moved frequently, sometimes across the country, which resulted in a number of different school placements in various cities during her junior high and high school years. Janet felt alone and lonely as she could not build long, lasting friendships with peers. Since her parents' divorce, she had withdrawn, tending to isolate herself from her peers and had became unwilling to build friendships with others. In addition, as Janet grew older, she had many unanswered questions about her missing sibling, her natural father, and the reasons that she was not allowed contact with them. Discussion about such topics was actively discouraged in the household.

In her teenage years, Janet's participation in extracurricular activities was primarily an attempt to gain her mother's love, approval, and involvement in her life. When her attempts proved futile, Janet felt a repetitive and increasing sense of pain and hurt. She felt that her mother constantly compared her to her younger siblings and that she could not measure up to this comparison. During her mid- teens, the relationship between Janet and family members improved until marital difficulties between her mother and stepfather disrupted the family functioning. Janet felt that she and her mother had been in the process of strengthening their relationship; however, her trust in both parents was destroyed by their actions during the period of their difficulties. Janet attempted suicide by drinking liquid iodine in combination with Tylenol at the age of 15 and was hospitalized. When she returned home, her suicide attempt was not openly discussed nor acknowledged by family members except to send her to a psychologist to obtain help. However, Janet felt that she was unheard, that the psychologist was aligned with the mother, and after a few sessions refused to return.

When Janet finished high school, she moved away from the family to eastern Canada to begin attending university where she enrolled in a bachelor's degree program that she subsequently decided was a poor choice of profession for her. As a result, she withdrew from the program and returned to her parent's home. She felt full of hope that her life would

improve and that she would be able to prove that she could be successful, independent, and worthy of being loved. Her second suicide attempt occurred at the age of 22 after a number of events within a short period of time: including the breakup of a long-term relationship, family discord, and academic difficulties. Janet felt that she was a failure and that life was far too painful to continue living. After taking sleeping pills and slashing her wrists at the family home where she had returned to live, Janet was discovered and taken to the hospital. In both suicide attempts a primary precipitating event was an argument with her mother, from whom Janet continued to feel a strong need for love and acceptance.

Janet indicated that since childhood she has experienced continued low levels of depression that become intense when difficult events occur in her life. Since her second suicide attempt, she has developed ways of dealing with feelings of sadness, hopelessness, isolation, and futility. In addition, the development of a strong bond and open lines of communication with her mother have provided her with a sense of security and love that she previously had not experienced.

LISA

At the time of the interview, Lisa was a 25 year old, unmarried woman who had recently completed a Bachelor of Arts degree at a western Canadian university. She had found employment in the field of her choice and was beginning to feel established in her new life.

Lisa's parents divorced in her infancy. At this time, the children of the marriage were separated, the older children staying with their mother and Lisa moving with her father from eastern to western Canada. She had little contact with her natural mother for most of her childhood but was allowed to maintain her relationship with her siblings. Lisa's father remarried and had several children. Lisa described her perceptions of never truly feeling as if she belonged to the family unit in which she lived.

As she grew up, particularly in her late teens, she felt an increasing sense of anger and resentment toward her parents for the break up of her nuclear family. Despite her sense of alienation, Lisa's step family provided a secure and stable environment during her childhood.

Lisa was a good student in school, particularly in her high school years. She performed within the top of the class and found learning easy and enjoyable. Lisa had a well established group of friends with whom she felt secure. During her high school years, however, Lisa began to experience depressive episodes and became involved in bulimic episodes in an attempt to obtain the perfect body. She indicated that the depression and bulimic behaviors, which continued into her university years, increased as her feelings of alienation from her family increased and her questions went unanswered as to why her mother had deserted her in childhood. During this period, Lisa's father refused to discuss past events with her.

After graduation from high school, Lisa lost contact with the majority of her peer group when their paths became divergent. The loss of this support group became a significant factor in her life. Lisa enrolled in university directly after high school with the goal of being accepted into a highly competitive field after a pre-professional year of general studies. She was unable to maintain a high enough academic performance level to be accepted into the career program of her choice and the growing realization that her application to the program would be rejected was very difficult for her to accept. She felt that few career alternatives were available to her and that, having failed at admission to the program of her choice, there was little future for her. She felt like a failure and worried about her perception that she had let other people down.

At the age of 20, Lisa felt that life was no longer worth living. She fell into a deep depression which compounded her perception that she was a complete failure. She decided that suicide was the best option since she saw no future for herself . She planned to take her life by ingesting a large bottle of extra strength Tylenol. She became extremely ill after taking the Tylenol but was not hospitalized. She did not disclose

her suicide attempt to her parents but did to the psychologist she saw shortly after the attempt. Her suicidal thoughts continued for a two week period after which her depression began to lift to a more manageable level.

Lisa sought counselling for the issues that were troubling her, primarily her anger toward her parents and feeling alienated from the family unit. She was able to resolve some outstanding issues with her father, and find a career path with which she was satisfied. Lisa has also built a social support network that provided her with a sense of security that she was lacking at the beginning of her university career.

RYAN

Ryan is a 26 year old, unmarried male. He grew up in a mid-sized Canadian city, obtained a university degree. At the time of the interview he is employed as a health care professional. He grew up in a loving family with two siblings. He struck the researcher as a kind and gentle individual who had a tendency to think of the welfare of others before he considered his own.

Ryan's earliest memories include feelings of his being different from family and peers because of his emotional sensitivity. He felt vulnerable because of his tendency to respond to situations with more emotional intensity than others. He perceived himself as being easily hurt, unable to defend himself against the cruelty of peers, and highly sensitive and aware of the response of others in social situations. He felt targetted and ostracized by his peer group throughout his school years and described himself as having difficulty in understanding the rules of his peers social behavior. Although he acknowledged his parents' love and support, he did not feel understood by them or his peers. As a result he developed strong feelings of alienation and being different from others and had few friends until he reached university.

At the age of 10, Ryan decided that life was so difficult and such a

struggle that he thought of death as an escape from the pain of not feeling able to be close to his peers or family. He took a bottle of aspirin in an attempt to die. He described this as an impulsive act of desperation and a cry for help. His parents responded with concern and attempted to make adjustments in Ryan's home life that would alleviate his sense of distress about his life.

In his adolescent years, Ryan's sense of isolation and alienation grew because his interactions with peers did not improve. His parents transferred him to new schools frequently because of his reported difficulty in interacting with peers and suffering from peer rejection and cruelty. In one school he spent the last months of the school year in the staff room completing course work because of emotional cruelty perpetrated by his peers. Although he wanted to interact with others his age, he found himself ostracized and isolated as his behavior was different and did not fall within acceptable peer standards. Something set him apart which caused him great pain and sadness.

Ryan was diagnosed with depression during his junior high school years and several attempts at different types of medication and therapy failed to alleviate his symptoms. He felt sad, disheartened, rejected, misunderstood, and lonely for most of his adolescence. The intensity of peer pressure to conform and to socialize in a rigid and specified way abated in high school when individual differences were more acceptable within the adolescent population. During his junior high and high school years, Ryan was dealing with the growing realization that he was homosexual. He struggled with the conceptualization but talked with no one because the idea of being homosexual created anxiety and fear of rejection from family and peers.

Ryan proceeded immediately from high school to university. During his university years, Ryan engaged in an active social (but never sexual) life and found individuals with whom he was able to create friendships. He had two distinct groups of friends, those within the gay community and those within the heterosexual community, the two of which he carefully kept separate. He found the pace of university life and

the responsibilities of young adulthood increasingly stressful and difficult. He was living independently from his family but was able to maintain close ties to family members. He had significant mood swings of highs and lows and found it difficult to balance his relationships, school demands, financial concerns, and family interactions. Although he was on medication for depression, it appeared to do little to alleviate his symptoms.

At the age of 21, Ryan was receiving therapy from a psychiatrist during the winter months and set a time line for disclosing his sexual orientation to his family members sometime during the upcoming summer. Just before final exams in his third year of university, Ryan realized that he was experiencing extreme distress and began spending more time in the family home. As he felt that his life was increasingly out of his control, he began to engage in risk taking behaviors that sometimes jeopardized his life. A culmination of poor academic performance, fear of disclosing his gay identity to family members, guilt about his sexual orientation because of strong religious beliefs, and a lack of perceived control over his depression, compounded an overwhelming belief that he was incapable of surviving. In addition, Ryan received prescribed medication to which he had severe adverse side effects that exacerbated his feeling that life was overwhelming. He saw himself as a burden to those around him.

Ryan made a serious attempt to take his life by overdosing on antidepressants which resulted in hospitalization. He described his life as spinning out of control, and he saw little possibility of improvement in his depression prior to the attempt. While still in the hospital following the suicide attempt, Ryan disclosed his sexual orientation to his mother despite his fear of family rejection.

Since his disclosure, family acceptance of his sexual orientation, successful completion of his university degree, and an effective drug regimen have facilitated Ryan's ability to gain self acceptance. He now has the perspective of being able to direct his life. After graduating from university, Ryan has maintained successful employment, continues to

learn how to control his depressive and manic episodes through increased awareness and the use of effective coping strategies. He and his parents are actively involved in promoting community understanding and acceptance of gay and lesbian issues.

Chapter Five

Results

Theme 1 - Childhood Beginnings

All participants began to disclose their experiences of attempting suicide by remembering and reflecting on childhood events. These diverse, and yet very particular childhood experiences, were deemed to be large contributing factors in their decisions to attempt suicide during their teen and early adult years. The issues surrounding and permeating these events, as well as the encounters with their parents, step-parents, siblings and peers, were unanimously understood as somehow providing the groundwork and foundation for their life-long perception of self as inadequate individuals. It was a perception that was always in sharp contrast to their view of others as competent and worthy.

When relating the events of their lives, Ryan, Elaine, Janet, and Debbie each began their stories with very early childhood memories. Even though Lisa began her story in her later childhood years, she subsequently returned to her early childhood, in the effort to provide context for her life experience. The impact of their changing roles within the family, the interactions between family members and the extended community, and their perceptions of safety and security were spontaneously identified and discussed by each participant. Excerpts from the transcripts are provided in the participants' own words to serve as exemplars of their experiences. Their excerpts are shown as indentations.

The family remembered

Three participants experienced the separation and divorce of their parents at an early age. Lisa, Janet, and Elaine expressed a common

experience of the family break-up to be one of shock and surprise. The dissolution of the family left them feeling vulnerable and confused, and they wanted reassurance from either or both natural parents. In all three cases, the relationship with the non-custodial parent was severed for most of their childhood and reestablished after the suicide attempt that occurred in early adulthood. In each case, the custodial parent remarried quickly after the divorce or established a new relationship that left the participants feeling displaced and unwanted. Family relationships and interaction patterns changed to such an extent that, as children, each experienced significant upheaval in their lives.

Along with the establishment of the new relationships in the parents' lives, came the child's sense of being unimportant, displaced, and a burden on the parent. The process of accommodating the parent's new love relationship significantly altered the routine and subsequent security that had been established by the previously intact family.

In Janet's case, having a brother sent away without warning or explanation left her with the fear that she could easily be the next child to be banished from the home if her mother felt so inclined. Lisa, on the other hand, felt insecure as a result of feeling that her stepmother could not provide her with the type of mothering that she thought she would otherwise have received had her natural parents not divorced. Despite this, she exhibited little overt distress or tension while she was growing up:

> In terms of the family itself, there was some stuff that I hadn't dealt with that my parents had split up and I had gone with my dad when I was four and a half so I had my dad and my step mom. There was a lot of insecurity there because I had never dealt with any of it. I didn't really have a mom and I didn't, well, they had their own children so I kind of felt out of the family.

Janet also felt that there was no place for her in the new family system. Not only did she experience the family interactions as uncomfortable and strained, but her experience of continual tension within the family environment was compounded by her perception of being targetted as a

scapegoat by her mother. For Janet, feelings of being unaccepted and unloved by her family led to her withdrawing from interaction with peers and other adults that could have provided her with support and encouragement:

> I guess it would have to start way back. Ever since I was young, -- my parents got divorced when I was 5 and I always kind of [pause] for a long time I just sort of secluded myself from other people and that really had an effect on me. I didn't really feel like I belonged anywhere. My mom got married a year later and there was always conflict in my family. She wanted me to get along with my new dad and I never did and I always felt alone in that my family didn't want me. I guess I figured that my mom hated me and she took things out on me because I was someone else's child.

Elaine's life changed not only in family structure, but with a move to a new location that separated her from the support and love of her grandparents. At the time of the move, she remembered her life as undergoing significant change. Prior to the move she remembered herself as a happy child who did well in school, whereas after the move, her memories of school and the family reflect an increasing sense of discomfort and unhappiness:

> So they only focussed on the bad and so I just kept getting negative and negative. I remember that right away, as soon as we moved there, and things just got worse and then they got divorced and my mom took off to [a city] and lived with this absolute asshole. I remember him because he gave me a licking with a metal fly swatter one time and I fought him so hard, and it hurt really bad. Then we moved back to [a small town], started seeing our dad, she kicked this guy out and then she got to be with P -- the guy she's still with. So it was. It was gross. When we did go see my dad, he was drinking so, basically I took care of my brothers during that whole time. I mean, I had to clean the kitchen so I could get them something to eat. I was in grade six when he came back, so grade six, -- every time we went out there, I had to cook and clean just to take care of my brothers -- make sure they had a bath, make sure they went to bed on time. I wanted to be out there playing with the boys and flirting, I was at that age. Yet I couldn't. I could but then nobody would take care of my brothers and I couldn't do that....He [father] always had money for

> booze, he always had money for cigarettes, he always had money for a bag of dope, but take us to McDonald's or to remember to pick us up on the weekends, you know, it just didn't happen sometimes or he'd forget about us....Then he left and I didn't see him for over eight years.

Her father's alcohol problem forced Elaine to take on responsibilities for her younger siblings and a part time adult role in the family unit. Meanwhile her mother's focus on developing new relationships and working to support her children left Elaine and her brothers feeling alienated. In addition, the family moved once again when her mother established a new love relationship, and once again Elaine felt not only unwelcome and insignificant, but harangued in the home. She described the change of living conditions, from rural to urban, and from financial struggle to wealth, as culture shock:

> We moved from a small town to the city. We moved into a big huge house so we went from living on a dairy farm in a mobile home to a 3,500 square foot home. [pause] And you know, this house was his and "Don't go in that room" and "Don't go in that room," "You guys can use that bathroom only" [pause] all these bull shit rules. "You're kids and you're not allowed in here. You go downstairs and play." And that was it. "Don't touch the walls when you walk by", God forbid a finger print would get on there. I remember my brothers getting yelled at so much. I didn't get yelled at that much [pause] I kind of just knew what that person wanted and just did it to please her. But my brothers, I remember them getting yelled at. So that was really gross again.... a big adjustment.

In addition to the need to adjust to a new family situation, new relationships, new location, and new lifestyle, Elaine had a sexual encounter with her stepfather while in her mid teens:

> When I was, I think 14 or 15, I can't remember exactly, she went away to Ontario to visit her father who was sick. During that time, I got sick. He gave me a pill, I ended up in his bed. To sum it up quickly, he was rubbing my breasts and told me all sorts of bullshit and things like that. So from that period on, I hated my whole life even more.

Elaine did not disclose the incestual event to anyone. She felt betrayed, angry, and more vulnerable in the home than she had previously. In addition, she was experiencing extreme disgust toward her stepfather which interfered with her ability to maintain a composed demeanour when he was present. Elaine indicated that she tried to protect her mother from the truth and was concerned that her mother would either blame her for what had occurred with the stepfather or deny that the situation had occurred at all. She felt the need to escape from her distress but did not know how to accomplish that.

Debbie and Ryan on the other hand, reported that they came from intact families. However, in both cases, the fathers suffered from manic depression and were receiving ongoing medical and psychiatric attention. Living with a parent who suffered from manic depression was an experience that left both Debbie and Ryan feeling vulnerable to their fathers' unpredictable mood swings and behaviors. The fathers' disorders were highly disruptive to daily functioning at both an individual and family level. In Debbie's case, her brother, as well as her father suffered from the disorder. The brother returned to live at home when he was unable to function independently, and this move compounded the unstable family dynamics. The household was in a constant state of upheaval and uncertainty. Debbie felt vulnerable to the emotional uncertainty of the home and unprotected against the emotional assault of her brother:

> My father is a manic depressive and my eldest brother also is manic depressive and so it was really really difficult growing up around that. He [brother] lived with Mom and Dad for the ensuing five years or so, five, six years or so. And it was you know, it was murder living with him because he was so critical and, I mean he was ill but when you are 14 you don't see it that way. You take everything, I took it very personally and he pretty much eroded my self worth on a day to day basis, and I was scared to come home from school, because I didn't know what I was in for, or what he was going to do. He was constantly putting me down. I think it probably goes under the category of emotional abuse, like psychological abuse.... He even said this at one point that, because he had had such a rotten childhood with Dad, he got physically abused and stuff by Dad, but

> because he had such a rough childhood that therefore I didn't deserve any better. That I should have, so that he wanted to see to it, that I had a really shitty childhood too. And I started to feeling like I wasn't worth anything, and my Mom had gone back to work at that point. So a lot of the time she wasn't around, so you know I would go home and it was just him and I whatever, and, so he would kind of vent on me, you know. He was angry at the world and angry at women and the whole nine yards. I was an easy target.

In addition to dealing with the difficulties presented as a result of her father's and brother's illnesses, Debbie had also been subjected to sexual interference by another brother in her early childhood and again in early adolescence. Her difficulties dealing with mentally ill family members, compounded by the sexual interactions with her brother, left her feeling alienated, unworthy, and unable to cope with the problems in her life by the age of 14:

> I was having a really hard time because I had been molested by the youngest brother.... when I was about six, and then again when I was about 13, and then nothing after that, but by the end of my 14th year, I don't think at the time I knew that was why I was so miserable.

As was the case with Elaine, Debbie did not disclose the sexual encounters to anyone and felt that she had no protection or support within her family, particularly in her teenage years.

In contrast to Debbie and Elaine, Ryan described his family as supportive of his personal growth and struggles; however, he recalls having difficulty in relationships with his siblings. He felt that he was compared unfavourably to a brother who appeared to receive the majority of his father's love and attention. Ryan's own struggles with depression in childhood largely overshadowed his memories of the impact that his father's disorder had upon the family unit. He remembered, however, the unpredictability of his family interactions and the fact that his personal struggles were often compared to similar struggles and behaviors demonstrated by his father.

Communication and care

The inability of parent and child to communicate on a personal level about issues of importance or concern was a consistent theme with all female participants. Therefore, as children and adolescents, while there was a desire for closer connection and understanding with the parent, it appeared to be an unattainable goal. Lack of communication was interpreted by Elaine as lack of caring by her mother:

> I couldn't go and discuss with her obviously my options of how I want to dress and how I want to be. I couldn't discuss with her the possibility of me living somewhere else. She's just not the kind of person you discuss things with. I was really mad at my mom for pretending everything was o.k. I remember thinking how she doesn't care, I don't want to be here.

In an interpretation similar to Elaine's, Debbie felt that her mother's actions were indicative of a lack of care. While she understood her mother's need to return to work to support the family, the mother's absence increased Debbie's perception of a lack of protection. In addition, Debbie felt that her mother had little time or energy for her, and no other family member appeared to show love, affection, or concern toward Debbie in ways that she perceived as helpful. Open and honest discussion occurred infrequently in the household and when attempts were made by others, they were often rebuffed by Debbie herself:

> She didn't ask me that. But then there were other times when she would try to get me to talk to her and I wouldn't talk to her. So I think, you know, I didn't really help matters.

Janet shared Debbie's perceptions that there was little care for her in the family unit. The message communicated to Janet most frequently was that she was a burden to the family, particularly to her mother. In addition, Janet also felt that she was somehow partially "responsible" for the current state of affairs. Regardless of the questions or concerns that Janet had, particular topics of discussion were forbidden or discouraged and answers

to Janet's questions were not provided:

> I missed having the family atmosphere like everything was just blown apart when I was 5 and I never sort of was able to put it back together. Everything was just scattered and my mom never let me talk about my real dad or find out why she sent my older brother away because I knew that he was a big thing in my life then and we were really close and one day he's there and the next day he's gone.

Lisa was left with many unanswered questions about why she had been the one child to remain with her father following the divorce when her siblings had remained with her mother. No answers were provided to her questions, and she hesitated to raise them because of concern about her father's responses. It was clear to her that the topic was not open for discussion. This mirrored Janet's perceptions of her family situation and the questions that she had about why contact with her natural father was not allowed and why her brother had been removed from the home. Because of their questions, both girls created answers for themselves, but were unable to pursue the accuracy of these explanations.

Debbie and Elaine both interpreted lack of communication with their parents as indicating that they were not important people, an assumption that impacted on family interactions. Both felt the need to protect themselves from family members and limited interactions and communication as much as possible out of a belief that their concerns would remain unaddressed even if they were expressed and explored.

The nature of the changes that occurred in the lives of Lisa, Janet, and Elaine were such that all three questioned their individual importance within the family. In addition, each perceived that the timing and nature of the change in family structure had a significantly negative impact on the quality of their relationships with both natural, and step parents.

Summary

A home is ideally conceived of as an environment in which children can feel comfortable, protected, and at ease with themselves and others.

The generally accepted purpose of the family in our culture is to create a place that acts as a haven for nurturance and growth. It is usually perceived to be the one place where individuals can experience love and acceptance, where one is valued for what and who they are. Debbie, Elaine, Janet, and Lisa all indicated that they felt separated from the safety and security that is typically thought of as being representative of home life for children. Even for Ryan and Debbie who lived in two parent families, home and family were not experienced as safe or secure environments due to the unpredictability of family interactions.

For each of the participants of this study, disruption of home life was identified as a common source of strife and discomfort, that gave rise to a lasting and profound sense of uncertainty, fear, and self doubt. Not only was disruption and fear typical in the lives of these individuals, but loss was a major factor. Each participant experienced one or more of the following: loss of the family unit, relocation that resulted in loss of support networks and/or extended family, loss of relationships, and loss of their place within the family. Their lives showed a pattern of disruptions that created the ambiguous and unpredictable context within which they developed as individuals. Therefore, the disconnected family home was the rocky foundation upon which these individuals built a perception that they were not valuable, valued, or important people.

Theme 2 - The Adolescent Years

First encounter with suicide

Four participants, Ryan, Janet, Elaine, and Debbie, each made an attempt to end their lives in their late childhood or early teen years. Each felt a depth of alienation and desperation that convinced them that life was not worth the continuing struggle. These attempts were described by Debbie and Elaine as a response to feeling overwhelmed with events or emotions that seemed beyond their individual control. While Ryan and Janet agreed with that perception, they also described their attempt as being a "cry for

help".

The suicide attempts were remembered and explained as being impulsive, without extended forethought or planning, and appeared to be a reaction to a variety and large number of distressing precipitating events. The method each chose to attempt to take their life was based upon what was available and accessible within the home. Each attempt was made within the family dwelling.

As Elaine described her childhood, she described her first suicide attempt as follows:

> I think I was 13 or 14....I don't really know what led up to that one as much, it just kind of happened one day, I was mad and just hated things and decided to take a bunch of Tylenol. Obviously it didn't work, I was sicker than a dog.

Ryan found that he was incapable of connecting positively with his peers or his family. His inability to establish and maintain friendships was particularly difficult for him to handle. He felt vulnerable, rejected, and unable to understand why he felt so emotionally distressed so frequently. At the age of 10, he thought of death as an escape from the pain of living. Ryan described his first attempt to die as an impulsive act of desperation and a cry for help to anyone who would listen:

> That's why I climbed up, got the aspirin and just started taking them one by one. I know I didn't take the whole bottle but I just started taking them and taking them and just wishing it would end and that. I mean now, being old, I guess you can look at it and I guess it's ironic, but some of those events that I told you hurt more than trying to commit suicide, if that makes any sense. I know I didn't take the whole bottle and I was fortunate because when I went in, they put some kind of tar or something that sort of neutralizes your stomach and you're able to flush it through your system.

Janet's sense of frustration and desperation was described as a direct response to her family situation. As she grew older and attempted to gain her family's love and acceptance, particularly her mother's, she became increasingly frustrated with her inability to build the strong relationship that

she felt she needed. Unable to obtain the love and acknowledgement that she longed for and feeling increasingly rejected by the family, not to mention having a loud and distressing argument with her mother, she made the impulsive decision to attempt to take her life at the age of 15:

> Nothing seemed to work. So at 15 I remember I got into a really big fight with my mom.... I had some iodine and I drank that and I took Tylenol but that didn't work and so she took me, well, the ambulance came and I went to the hospital and they pumped it out of me and the nurse asked why I did it and my mom said "Oh, it's because she got into a fight with me." but that wasn't really why. It was a lot more than that.

Janet was unable to discuss with her mother the issues that caused her distress either before or after the suicide attempt. Despite her cry for help, Janet was unable to reach her mother.

Debbie's first suicide attempt occurred as a result of experiencing difficulties in most areas of her life. She began having difficulty in school and frequently pretended to be too ill to avoid attending. She felt alienated from her peers, but was able to maintain one close friendship that she could rely on. The difficulties of daily functioning within the home environment were becoming increasingly distressing to her:

> So the whole social picture was screwed up and the home picture was screwed up and academically it was a mess. So I think it was an amalgamation of all those things.

Debbie also began to feel that she was the problem within her family, and not others. There was no area of her life in which she felt she was receiving positive support or was appreciated for her uniqueness. As a result of her brother's continual criticism, the sense that she lacked any value as a person and that she was worthless and unimportant was exacerbated, and she too, attempted to take her life.

> So I started to think that well I wasn't worth anything. I thought, you know you internalize when you are that young what people say about you. So, I think I was about, just about to turn 15, and I took my Mom's

> entire bottle of Halcion, which I'm sure you know is sleeping pills. I think, I can't remember, I think it was about 30 pills or something like that and whatever booze that I could find in the house. My Mom had some like Tia Marie stuck in her closet or whatever, little things of it. So I would drink that and I became pretty out of it and no one was around specifically.

After the attempt

Following their attempts, Janet and Ryan both received immediate medical intervention. Although Debbie and Elaine became very sick, they did not receive medical attention. With the exception of Ryan, the response of the family members to the initial suicide attempt was mostly negative and only served to reinforce the preexisting perception held by each the participants of a lack of personal worth and value. While Ryan's parents were quite concerned with what he had done, the action they took revealed that they understood Ryan's attempt as being a result of factors outside of the home. Therefore, the overall response of significant others to the suicide attempt left each individual feeling either punished, misunderstood, or unimportant within the family context. Debbie captures this lack of support following her first suicide attempt with the following words:

> But at that point it was really painful to me that she didn't sit down and say, "So by the way, why did you take all my pills? Why? Are your trying to commit suicide? Is there something wrong?" You know, or "Did you just do it for fun?" type of thing. She never did try to ask me to find out why I would do that. She just punished me for it. So that really wounded me.

There was little overt parental follow up or discussion to deal with issues that may have contributed to their feeling that the option of ending their life was the most viable alternative. For all of the female participants the suicide attempt was not discussed within the family context or within the context of the parent/child relationship. In addition, all the participants felt that the other family members actively attempted to disengage from the problem. Elaine expressed this response in the following manner:

> I ended up grounded is what happened. It was really horrible. I obviously should have been in help then and go see somebody.

Debbie added:

> Nothing changed there, no one seemed to really notice that something was wrong with me. Nobody paid attention, like Mom certainly noticed that her pills were gone and she was certainly angry and punished me. But nobody else seemed to really notice, like George didn't pick up on this. My dad didn't and everybody else was moved out by then. I don't know whether Mom told them or not. But it seemed like nobody knew and if they did, they didn't care.

Summary

Not receiving attention or assistance from the parent or siblings after the initial suicide attempt reinforced in each participant the feeling that they were uncared for, that they were unimportant within the family unit, and that their problems and distresses went unnoticed by other family members. Elaine, Debbie, and Janet all noted that they felt that the role they played within the family was inconsequential, a feeling which reinforced a belief that, as individuals they must be insignificant and essentially worthless. This was a belief that would continue to haunt them. It is a noteworthy point that all of the participants felt that, had there been some caring and thoughtful intervention at this point in their lives from family members or from professionals, the personal road they travelled would have led them away from considering suicide. It would have ceased to be a viable alternative.

The peer group

For each participant, peer relationships played a significant role, particularly in the teen years. Elaine and Lisa had well established peer support systems, and turned to their peers rather than to family members for support, solace, and understanding. Debbie, Ryan, and Janet, on the other

hand, felt alienated and isolated from peers. While Ryan and Janet had experienced this separation since childhood, Debbie's sense of alienation began and grew as she advanced in her teen years. Alienation from peers reinforced Debbie's growing belief that there was something inherently wrong with her as an individual:

> I wasn't connecting very well with friends at school any more. I didn't fit in socially, I was overly serious and I didn't have fun like they all did. So I felt apart from them and that was getting me down and it got me down. I thought that I was really messed up and that there was something wrong with me, because I couldn't be like them and just be carefree and happy-go-lucky and have fun, you know. Go out and do like whatever teenagers do and not think about things as seriously. So I thought I was really fucked up because I wasn't like them and I felt that something was wrong with me.

Ryan's alienation from his peer group was initially rooted in his inability to comply with peer-prescribed rules. As a young child he remembered feeling that he did not fit within his peer group as a result of not enjoying activities usually associated with being male. He felt uncomfortable with the rough and tumble play of other boys. Ryan felt that he was different in that he could not, and did not, adhere to the rigid peer boundaries regarding allowable and acceptable social behavior. He found the social rules of his peers to be cruel to others and difficult to understand, and he found himself unable to conform. Ryan indicated that his preference for considering the positive aspects of each person as an individual, regardless of their social desirability, resulted in rejection by his peer group as a whole. He suffered from being ostracized, criticized, and alienated by peers:

> You have the big social event - the school dance and I'm dancing with these two girls - one who was deemed as, later I found out, as the ugliest girl. That's not nice to say. I couldn't understand these concepts and how could people judge one another and that? I mean it's grade seven, but I don't know [pause] I'm not in these people's bodies, I don't understand their frame of thinking and I thought nothing wrong to dance with her. Then the other guys told me after that this isn't appropriate, that there's this girl that liked me and that was the person that I was supposed to be socializing with and I just

> did everything wrong. I also danced with a girl that was handicapped at the school and that was the biggest mistake.

His problems with peers continued from childhood into his late teen years, and Ryan had no long term friendships until his university years. As he grew older, he attempted to compensate for feeling isolated and alienated from others by maintaining a large number of acquaintances. He felt that by having a large number of people that he knew, acceptance could be obtained through sheer numbers. What he lacked in quality, he would make up for in quantity.

By the time he attended university, Ryan had two established peer groups that he interacted with on a regular basis. The peer pressure he began to experience was significantly different from that of his childhood. His depressive episodes were becoming increasingly severe, were occurring with more frequency, and were interfering with his ability to function effectively. Despite the additional weight of his emotional struggles, Ryan did not feel that he had the freedom to set his own agenda and deal with his personal issues. His perception was that he needed to keep up with his friends to prove that there was nothing wrong with him:

> I had to keep up with my friends. If they were in first year, I had to be in first year. If they were in second year, I had to be in second year. I couldn't take a year off. That wasn't right.

For some time Ryan found the peer community within the university setting as supportive. However, it was at this time that Ryan was becoming increasingly aware that his sexual orientation was different from most of his peers. As his awareness of this difference grew, his anxiety about being different increased. In order to cope, he established two groups of friends based on their sexual orientation and did not disclose to either group his own sexual orientation:

> Here guys and girls are already match making and here you are as a gay individual...just lost and....you're trying to live two worlds. There's one that you're trying to understand yourself and there's another one

> where you're trying to relate with the rest of the world the way it's supposed to be and that.

Ryan found the struggle isolating and lonely. He began to lie to his family and friends about his activities and whereabouts and lived under the threat of being discovered. As time wore on, so did his sense of being torn, of living a double life: One life to please others and another to please himself.

> As a gay individual and probably as a depressed individual, leading two different lives. The depressed one, you go out, you're happy, smiling outside [pause] maybe really you're not feeling that great inside. As a gay individual too, you know [pause] you put on a face. You live two different lives.

In the debriefing interview, Ryan indicated that he had chosen to take a university degree that his parents had favoured rather than enrol in the degree program that interested him. He did this because he placed his first priority on pleasing others. Having found peers with whom he was able to connect, it became important to Ryan to maintain those connections, even at the cost of personal sacrifice. Therefore, in addition to attempting to please his parents, Ryan felt that he must meet the expectations of his peer group in order to maintain their acceptance of him.

Janet's lack of involvement with a childhood peer group was similar to Ryan's except that it was by choice. Initially it was more due to circumstance and as she matured it became more of a personal stance that she became aware of only after some time. Isolation and loneliness were recurring feelings in her childhood, but Janet noted that she chose to limit her interactions with peers because of her inability to maintain long term friendships:

> I guess also because we moved around so many times, I didn't have that. I didn't have friends from years and years like growing up with them and stuff like that because we always moved around and I guess just basically at that time I remember feeling that no one wanted me or that I wasn't good enough no matter what I tried or what

> I did....I remember being in elementary school and I'm still involved in gymnastics and stuff like that, but I remember being in the lunch room and kids were asking me to come sit with them and I wouldn't. I'd just go sit by myself and I never at the time understood why until I got older.

By high school, Janet was able to establish and maintain a small social network. However, she continued to feel alienated and alone:

> In high school I was more concerned about doing well and making my parents proud of me so I wasn't really into being popular and stuff. I had a few friends and stuff like that, but still I felt quite alone.

Janet felt unable to turn to her friends for support and assistance in her emotional struggles as she continued to believe that she was essentially a burden to others. She indicated that she did not know how to ask for help when she experienced difficulty and would withdraw from the support of friends when she needed it most. This pattern of peer interactions continued for Janet into her twenties.

Elaine and Lisa had well established peer groups that provided support, caring, and companionship during their teen years. Although in her late childhood Elaine's family had moved frequently, she remembered having little difficulty establishing friendships wherever she lived. In her mid teens, Elaine became involved with friends that her mother found offensive:

> I was into this group of kids and they were good kids, but they looked weird. They were the kind...the punk rockers, like, the guys had all these mohawks and we wore black - little black tops and big jeans and big boots and leather jackets and it was a fad and there's nothing wrong with those things. They look like they're such scary and dangerous people. I even look at them now and go oh....but I was one of them and I think some of them, they were kind, they didn't do drugs, they rarely drank, all they liked to do was express themselves in a different way. So I got into that more and more and more.

Adding to the difficulties that she had with her mother and stepfather, Elaine found herself in a position in which she felt required to choose between her friends and her family. She chose her friends and left the family home as a result of a confrontation with her mother.

> I got my nose pierced, I thought it was just the coolest thing. I go home and show my mom, she freaks. "You go up to your room and take that god damn thing out of your nose right now or I'll yank it out." She came up there with a pair of pliers. She was going to rip it out of my nose. So I was scared because she's got these pliers and she is red in the face and she is mad as hell. And I can't really understand why. It's my body, it's not a tattoo on my forehead saying 'stupid'. It's a fricking nose ring. It will grow in. So she said "no, you take it out. Take it out, take it out, take it out or I'll rip it out.' So o.k. I'll take it out, get out of here. So she left and I stayed in my room all night and I thought I'm out of here. So, I packed my bags, 3:00 in the morning and I drove off and that was it.

Through identification with, and support from, her chosen peer group, Elaine obtained the strength to take a stand against the rules imposed in her home and moved away from the family.

Lisa had a well-established group of friends with whom she spent her childhood and adolescence. She found support and reassurance in the group until graduating from high school when the demands of finding jobs and obtaining advanced education resulted in the loosening of the ties of friendship:

> We were pretty close in high school anyway and everybody left so I was feeling more alone anyway - friendship wise.
> Some of my friends didn't come to this university and some of them did. Some friendships had broken and everybody had gone into various programs and things. So yeah, I felt pretty alone too - that everybody was going along with their lives.

Losing the regular contact and support of long term friendships left Lisa with a sense of isolation, loss of support, and loneliness. She seemed to feel that she was alone and had little importance in life. The stability and security provided by an cohesive group was absent for the first time in her life.

Summary

For all participants the peer group seemed to play a pivotal role in helping them to discover something of themselves and provided the much needed support that they were all looking for. Whereas Debbie or Janet felt the increasing alienation that made them realize their individuality, Ryan experienced an awareness of the futility of leading a double life. Lisa and Elaine found support in the peer group that they could not find at home. The peer group worked as a foil so that some kind of understanding and differentiation could occur. Elaine was the one participant who was always able to establish herself within a group if she so chose, whereas the other four each experienced both the presence and absence of the peer group at some point in their development.

Developing risk taking and self-destructive behaviors

In order to deal with the ever increasing amount of emotional pain and social distress in their lives, four of the five participants had slowly developed a penchant for, and became involved in, risk-taking or self-destructive behaviors. Janet was the one participant who did not identify or discuss the development of a repertoire of self-destructive behavior, other than the self imposed exile from her peers. By the ages of 19 to 21, Debbie, Elaine, Lisa, and Ryan each had established patterns of harmful behavior that they reverted to whenever the emotional pressure surpassed tolerable levels.

Debbie had discovered drug use in her early teens as a means of coping. By her mid teens she was engaged in a lifestyle that involved heavy drug and alcohol use on a frequent, sometimes daily, basis. She had easy access to illegal drugs through both friends and siblings, and a supply of prescription drugs was readily available and accessible in her parent's home. By her early twenties, Debbie's social life and recreational activities were concentrated around the lifestyle associated with drug and alcohol abuse:

> Then Geoff had magic mushrooms, so we did some of that, smoked lots of hash, drank lots of beer and I started getting really high on these mushrooms, but not as high as I had been on other times that I had done it....When I went home, I was really upset and she [mother] could see that I was crying and the anxiety was building. So she offered me a Zanax, so I said yeah, sure. So I took that and I sat and drank the beers that I had brought home with me.

While her experience with alcohol, prescription, and non-prescription drugs initially satisfied her need to escape from emotional distress, Debbie slowly found that she needed to expand her repertoire of behaviors. Drugs and alcohol no longer provided as much of an outlet or escape as she required. By her late teens, she began to engage in self-mutilation as a means of releasing distress:

> I remember sitting at the typewriter in my parent's basement bedroom that I had moved into and late at night and I would drink like tons of wine or booze, beer or whatever, and smoke hash, whatever, if I had it. Just sit and type like hours and type poetry and stuff. I remember one night cutting my wrists with a blade and smearing the blood on the sheet, on the page that I was writing on. I don't consider that a serious attempt at suicide but I think it was suicidal because I wanted to injure myself....I know I was feeling pretty bad and feeling pretty down and I think that I wanted, I remember feeling that I kind of wanted to die but I didn't have the guts to do it that way. Like I didn't have the guts to cut my wrists deep enough and hard enough to succeed that way.

The frequency with which Debbie cut herself increased significantly within a short period of time. She found that she had difficulty controlling the urge to hurt herself, particularly when she was under the influence of drugs or alcohol. Although Debbie has been involved in group and individual therapy as an adult, she continues to self-mutilate when in distress.

In a fashion similar to Debbie, Elaine became involved in drug and alcohol abuse in addition to a long series of destructive and abusive relationships. She became heavily involved in cocaine use and subsequently lost her job because of her inability to function effectively. After

obtaining a job as a waitress in a bar, Elaine began a pattern of heavy daily drinking:

> I'm only 18, no job, I'm doing cocaine. This is really gross. I don't want this. So I started to work in a bar and that was good fun. Lots of money, lots of men, lots of "you're so beautiful" constantly. It's all just bullshit but at the time it was kind of what I needed. So the lifestyle just kind of turns into constant drinking.

The more that alcohol became the focus of her life, the more she felt that her life was out of her control and the unhappier she became. Denying both to herself and others that she had an alcohol problem, the downward spiral continued:

> So I drank and drank and drank for about two years straight and shitty relationships - one on top of the other. All gross, all physical, all lots of verbal and mental abuse. You name it, it was all in there. And just one dead end relationship to another and just bang, bang, bang and everything was getting worse and I was really unhappy and it's probably now...I would say close to six months before I tried to commit suicide the second time, I hadn't told anybody yet about what my step father had done so I went - I knew I needed help....I thought, I'm doing something wrong here. Because if you can't communicate, all that shit stays inside of you and getting drunk doesn't fix it. You let it out a little bit and then it's still all in there because you just did something else to make an ass of yourself that's going to make you feel bad.

When Elaine began to acknowledge that she was having difficulty coping with her life, she obtained the services of a psychologist who helped her begin the process of dealing with issues involving both her mother and her stepfather. With the assistance of the psychologist, Elaine began to realize that changes were necessary in her life and she made minor adjustments to her lifestyle. She refused to believe, however, that she had a significant drinking problem. She made some adjustments to reduce her drinking but was unwilling to admit that alcohol had as profound an impact on her emotional health as she later came to understand:

> I had quit working in the bar because I wanted to quit drinking. I

> thought I was drinking too much. I had no idea I was an alcoholic but I thought if I quit working in the bar and just maybe drank on weekends, I'd be o.k. But, I still made a complete ass of myself and still went home with strangers and did all sorts of obnoxious behaviour.

When drinking, Elaine was verbally and physically abusive to others around her. She rejected offers of friendship or assistance and attempted to maintain an emotional distance from everyone she met. Her relationships were strictly short-term and sexual. Elaine had figured out that if she rejected others before they had the opportunity to reject her, then she wouldn't feel like she was such a failure. She also realized that her sense of alienation and isolation from others was heightened through her own inability to accept care and concern from others.

While Debbie's and Elaine's risk-taking and self-destructive behaviors occurred on a frequent and chronic basis, Lisa, on the other hand, engaged in impulsive destructive behaviors for only a limited time. These occurred when she was experiencing a depressive episode just prior to the suicide attempt. The behaviors, which were restricted in nature and frequency, were targetted towards ending her distress and occurred only when Lisa was actively contemplating taking her life:

> I did some dangerous kinds of things. I would step out in front of cars; that way I don't have to do it myself.

Unlike Debbie and Elaine, Lisa frequently fantasized about engaging in dangerous behaviors but seldom acted on them. As she expressed her thoughts during the interview, she indicated that often the fantasies involved communicating her distress, loneliness, and need for assistance to her father. She characterized herself as being too weak to act out her fantasies and indicated that she often felt disappointed in herself because of this perceived weakness.

Ryan alternated between periods of stability, mania, and depression. During his depressive episodes, on an impulse, he would engage in random acts of self-destructive behavior. As discussed in a previous section, Ryan had difficulty limiting his activities to those that were concerned with his own

physical or mental health. In conjunction with his depressive and manic episodes, Ryan often found himself in situations in which acquaintances would make unreasonable requests of him, requests that he was unable to say no to:

> I was talking about people using me, not being able to say no to people and it hurts your body so much. You wouldn't believe. I could just cry thinking about it. People would ask you to do things and you'd be running around like an idiot.

As a result of his inability to set parameters around his behavior, Ryan's mental and physical health seemed to suffer. His depression became worse as he found himself unable to successfully meet the demands and expectations of others. As previously discussed, Ryan attempted to replace quality of friendship with quantity. As he reflected on this process during the interviews, it was acknowledged that this pattern was highly destructive to his positive sense of self worth and value.

Ryan often felt that he was letting friends and family down by not being able to meet an ideal standard. When this occurred, he found it difficult to face those individuals because of disappointment with himself. He also felt a high level of anxiety when he did not meet the externally or internally imposed standards of performance. On one occasion, when he had let down fellow students by not completing his segment of a group project to his satisfaction, Ryan made an impulsive decision to avoid a confrontation with fellow students by trying to have a car accident:

> I tried to ram the car. I tried to hit a pole on the road going down the street going south, but the car slid, it swerved past the pole. I told my mother about that and it was fortunate of the good Lord that I didn't hit it. I was going pretty fast - being anxious and all these additional pressures and not producing results, of course you're going to go fast....It just was so convenient. I mean, being anxious and that and speeding, if you could just hit that pole and it would just be over like that.

Summary

Reflecting on the development of self-destructive and risk-taking

behaviors, it was clear that each participant's repertoire expanded or became more complex over time. These behaviors typically began unintentionally and were primarily motivated by the goal of alleviating distress and emotional pain. While some were impulsive and engaged in rarely as described by Lisa, others became routine coping mechanisms as illustrated by Elaine and Debbie's use of drugs and alcohol. As a sense of desperation increased for Ryan, so did the severity and frequency of his risk-taking behaviors. As these behaviors developed and their impact was felt by others, each participant's sense of alienation and loss increased. Rather than alleviating distress, these behaviors began to take on a life of their own as their frequency and intensity increased.

Trying to do all the right things

As they discussed the events in their lives, patterns were identified showing that the participants attempted a variety of methods to either alleviate or solve problems, particularly as they related to interactions with others. In individual ways, each tried to develop coping mechanisms that they felt would help them gain acceptance and love from others, particularly from the family. Each attempted to do what they thought was expected of them or what was modelled by others.

Elaine, Debbie, Janet, and Lisa each discussed the restrictions they felt surrounded their attempts to earn love from those they valued. They were all painfully aware of the implicit and rigid rules that were imposed on them because they were female. Elaine explained this perception in the following statement:

> But you weren't allowed to be out there and be angry or be sad, you go to your room and come out when you're happy. So you just shove all that shit inside and be a happy little girl. So I kept doing that.

Dealing with the full spectrum of emotions in an honest manner was discouraged in each of the girls' families. Each felt that they were expected to be happy and pleasant and were restricted from expressing emotions that could be characterized as negative. Not being allowed to express emotions

of distress, sadness, or anger resulted in a lack of skill development required to effectively deal with these emotions in adulthood.

In addition to restricting their emotional expressions, Lisa and Janet attempted to gain parental approval by engaging in a variety of extracurricular activities and through sustained academic effort. Both succeeded easily in school but felt that they received little recognition or positive rewards for their efforts. Both were highly involved in student councils in high school and participated at the competitive level in physical endeavours. Janet described her active engagement in these activities as a method for trying to prove to her family that she had talents and abilities that could be acknowledged. Despite their attempts, neither Janet nor Lisa felt that they made progress in gaining parental approval or love. They described their experiences in similar ways:

> I always tried to behave like a good child - a good teenager or whatever but nothing seemed to work. (Lisa)

> I also wanted to feel approved of or that someone or something needed me. That maybe my parents would see I'm doing all these things and they'd want to come and see me and be with me - that type of thing. (Janet)

Both Lisa and Janet persisted with their attempts to earn love and please others well past their high school years, whereas Elaine gave up attempting to win parental love or attention in her mid teens and began to develop the self-destructive behaviors already discussed. Ryan, on the other hand, felt secure emotionally within the family but only because he allowed his family's wishes to determine his life. Having not developed friendships until high school, he felt compelled to work diligently in order to maintain peer approval and acceptance:

> I guess a lot of my energy was focused in friends and family and when things like university came along, boom, and school got increasingly hard as you progressed in the years. It was hard to balance all these things. You keep on doing for them [friends] and you can't keep up with that. Maybe the friends that I associated with and that made that whirlwind so much harder because I kept on

chasing people that I couldn't keep up with.

Ryan also struggled with the continuing battle of controlling the manic depression that came over him in waves of extreme highs and lows. He found these cycles were difficult to handle when added to the growing responsibilities of adulthood and university expectations. In addition, although not sexually interested in girls, he sometimes dated because of social expectations:

> You're trying to deal with your depression and trying to deal with being accepted in the world and trying to balance that all out. It's just coming on top of you and you're going to university. People are making more demands on you because you're getting older. You've gone past puberty, you're dating, coupling, parties, your social life is very difficult.

Although he recognized that he was gay, Ryan was not yet able to disclose his sexual orientation because of fear of rejection from family and friends. He bowed to the social pressure to date girls to create and maintain the image that he was heterosexual. Dating created an intense amount of anxiety that he tried to hide from others:

> I have a very outgoing personality so I'm inclined to go out and socialize and be with other people and it's going to make cause for more anxiety because I'm not interested in the women out there. Same time, I'm not looking for men, but I know when people approach for situations like talking about dating and that, that's where the anxiety increases because it would just be so easy to say oh, I'm gay and then end of subject. But I couldn't do that then....You're your own worst enemy is what it comes down to. You add the pressures to yourself that are unnecessary. I couldn't see it that way.

Debbie had different issues in trying to do the right thing. She had maintained close emotional ties with her family members despite continuing difficulties in family interactions. She described the family attitude as "we are a united, dysfunctional family who shall conceal our problems" and hide from the world. It pleased her parents to see the siblings work and socialize together, and Debbie understood that maintaining very close relationships

with her siblings was important to them. Debbie felt secure in her social milieu until her brothers began to indicate that she had become too dependent emotionally on them. To please them, she attempted to develop independence and build her own social network while continuing to maintain the close family connections:

> So in between practising and stuff, that [partying] was my social thing. I had started to break away a little bit more from my brothers who I had been very dependent emotional on all those years, even with the one that had incested me. I mean we were all buds. But I was finding that they, in fact they started to say " Boy you need to get a life" that type of thing. "You are too dependent", stuff like that. So I tried to do that you know, pursue my own goals and make my own social connections and activities and stuff. It was tough.

Summary

All of the participants in this study attempted in their own way to meet and exceed self-imposed expectations as well as those imposed by others. For Ryan, Janet, Debbie, and Lisa, their individual senses of self worth was based upon "doing", not upon acceptance of self. Being industrious and considerate of others, although unsuccessful, was used in an attempt to obtain support and attention, as well as to compensate for feeling unworthy and inferior to others. Elaine was the one individual who rejected social expectations and turned to a lifestyle of drinking, drugs, and numerous sexual encounters in an attempt to satisfy her needs. Debbie's involvement in drugs and alcohol occurred within an established and socially sanctioned milieu. The others attempted to perform well academically, function within acceptable social groups in socially appropriate ways, be active within their school and community environments, and live up to what they perceived to be the expectations of family members. All found the pressure to please to be too difficult to sustain for more than a few years. Trying to mould their lives to fulfill the expectations of others did not leave room to express their own needs and desires, find solutions, cope with life problems, or deal openly and honestly with their own issues of distress.

Theme 3 - Looking Out - Looking In

Throughout the discussions of their experiences of childhood, family interactions, and the patterns developed during adolescents and young adulthood, each participant explored and disclosed the emotional impact of their lived experience. As their lives unfolded, each had begun to expect inadequate interactions with family and friends, leading to predominately negative emotional experiences. They learned that others would let them down or be unwilling and unable to meet their needs. In addition, with each failed attempt to obtain support and assistance, their needs intensified and became more profound.

Rejection

Disruptions in family structure and functioning and unsatisfactory interactions with peers and connections were experiences that were shared by all participants. Changes in family structure and family interactions contributed to feeling rejected and unappreciated for several of the participants. Janet, Elaine, and Lisa each felt that these feelings of parental rejection were of primary importance. They all felt that they had been displaced by the parents' new intimate partner. The affection that was once channelled toward them was now absent and they found themselves involved in a competition. A competition for which they were ill prepared emotionally, let alone, to understand.

Ryan experienced rejection from his peer group during his childhood and early teens, but felt a strong sense of support and concern from family members. As previously discussed, Ryan's sense of rejection came from his peer interactions and perceptions that he could not adequately conform to peer expectations and standards. In addition to being rejected by peers, Ryan appears to have actively rejected the behavior of his peers because of his belief that an individual's feelings were important regardless of who the

individual was. By choosing this path, he became identified as undesirable by his peer group in childhood and particularly his early teens.

Although Ryan indicated that he did not experience rejection from family members, it was his greatest fear. Ryan had quietly observed other gay individuals being completely rejected and disowned by their families following disclosure of their sexual orientation. Not only did Ryan acknowledge that he would be rejected by friends within his church community as a result of the fundamental theological premise that homosexuality was evil, he further acknowledged what he was most fearful of was family rejection:

> I feel still to this day, well, I'm a very emotional person, that if my parents had never accepted me, I think I would have found a way to be successful [committing suicide].

Ryan struggled within himself between the growing need to declare himself as a gay individual and his need to protect himself from complete rejection and isolation from those he loved most.

Not only was Janet the recipient of rejection, but she used rejection as a protective mechanism from being hurt. She felt rejection as a result of the inability to please her mother despite all attempts. As she had no contact with her natural father, she felt strongly that she required her mother's approval, love, and support. However, far from gaining what she needed from her mother, Janet experienced only her mother's anger. Janet's interpretation of their interactions was that she was a burden, unappreciated, uncared for, and unloved:

> I felt that she really resented me. When I was younger she would say threatening things like I'll kill you and stuff like that and I always thought that she really hated me. I just felt really trapped and alone. I wanted to have this wonderful family and I got good grades in school and I did my best and everything that she wanted but nothing seemed to be good enough.

Janet always felt insignificant when she compared her relationship with her mother to her siblings relationships with the mother. As she related

her story, she indicated that at no time did she feel that there was fairness in these relationships or interactions and she struggled with trying to find answers to explain the discrepancies that she saw:

> I always felt that my mom cherished my brothers more than me and that she thought they were good kids because she was always saying when I was younger that I was a bad little girl and stuff like that and I could never understand why like why? I'd always be asking myself why and I thought maybe it's because I'm someone elses' daughter that she hated me that type of thing. She sometimes would say like you've made my life hell and stuff like that which would really hurt and make me feel like less a part of the world or insignificant.

Perhaps as a result of feeling rejected by her mother during childhood, Janet chose to reject offers of friendship from peers as a method of protecting herself from the pain of loss. The frequent family moves were upsetting to Janet in that the disruption or termination of relationships with peers was experienced as loss. Janet found that she preferred to maintain emotional distance because of her belief that friendships could only be temporary for her.

It was during her mid-adolescence that Janet developed a peer support structure that she felt comfortable with. She began to turn to peers for approval and support. In conjunction with building her friendship network, her relationship with her mother deteriorated as Janet separated herself from the family. Janet's suicide attempt in adolescence was precipitated by her feeling that her mother would always reject her regardless of any action on Janet's part to change the relationship.

The loyalty and emotional energy directed toward the new love relationship by a parent was interpreted as rejection and betrayal by both Janet and Elaine. Elaine indicated that because she believed that her mother did not consider her important, she came to believe that she was of secondary, if any, importance, like she was "nothing". In addition, both Janet and Elaine felt that their natural fathers had rejected them; Janet's, because the mother did not allow any relationship to be maintained with the father, and Elaine's, because her father's drug and alcohol problems interfered with his life to the extent that he had made no contact with her for

eight years.

Prior to the initial family move out west, Elaine had felt that she was accepted by immediate and extended family and by her teachers at school as a healthy, normal child. Following her move however, she felt unappreciated and rejected by school staff and isolated from family. Elaine indicated that she felt confused and upset by this change:

> After the move, all of a sudden I'm a bad student. I mean, I was in the principal's office, I was in the hallway, the teachers would shake me, the principal hit me on the head with a chalk board brush. Right away, I just turned into this bad thing (which I don't think I did) but they couldn't see the good parts of me, or something.

When her mother became involved in new intimate relationships, Elaine felt that there was little room for parental interaction that was constructive or satisfying. From Elaine's perspective, the demands of her mother's new life left limited time for the nurturance or care of her children. This change felt like rejection to Elaine and she began to form a foundation upon which she built feelings of being valueless, alienated from others, and out of control of the events of her life.

When she decided to disclose the sexual encounter with her stepfather due to the continual emotional distress it was causing her, Elaine anticipated receiving love, support, and understanding from her mother:

> I went to a family counsellor and talked to her about it [sexual encounter] and I decided to write my mom a letter and tell her about it because I couldn't do it face to face. She's got way too much power over me and I couldn't have done it then. So I sent the letter and she sent a message back saying, " Well thanks for the letter, it's a real doozey and no, I'm not ready to deal with this shit." And I was....hurt and angry and everything because I finally took this chance to have my mom say "It's o.k., I'll take care of you" and then she totally kicked me in the ass kind of thing.

Elaine described feeling as if she was the most insignificant person in the world following her mother's response. She felt demeaned and humiliated. She interpreted her mother's response as complete rejection of her pain and distress and could not believe that the outcome of her attempt

to be honest in her request for parental help would lead to rejection. Her mother's actions in the following months only served to corroborate her initial feeling of rejection, as the promises that were made by her mother were never followed through.

Like Janet, Elaine also used rejection of others as a means to protect herself from close personal interaction. She discussed her belief that she needed to hurt others as she felt it was inevitable that given the chance, they would hurt her. Elaine found herself to be a "horrible" person because of her disregard for, and rejection of, others.

Lisa found herself rejecting her step-family although she recognized that they made repeated attempts to include her in a meaningful manner. She did not feel that the step-family was her "real" family. Lisa did not openly behave in a rejecting manner, but did feel alienated from family members. In addition, she felt that her natural mother had rejected her by not attempting to gain custody of her as a child. When Lisa became older, she gave expression to this rejection via her anger toward both natural parents.

Similar to Ryan's perceptions previously discussed, Lisa feared rejection as a result of letting other people down by not being the calibre of individual she thought she should be. She had high expectations of herself and expected that others did also. By not being able to follow her chosen career path, she was frightened that friends and family would see her as a failure and therefore distance themselves or reject her outright. These perceptions were similar to those expressed by Janet who indicated that fear of failure was one of the most important factors in her early adulthood. After experiencing failure in post secondary institutions, both Janet and Lisa saw themselves as being inadequate, unworthy, and incapable of success in their endeavours. Lisa explained her self-evaluation as follows:

> I was planning to be perfect, wanting to fit a certain image. My family never really placed that kind of pressure on me, I think it was more of a school thing, a peer thing. This is a society thing I guess. This is what you're supposed to look like, this is what you're supposed to do. You're supposed to do everything perfect....But I couldn't measure up.

Janet became so discouraged with herself that she came to believe

that life had no meaning:

> I was just grasping for something, some sign of hope and there was nothing. So I was like well, I finally got to a point where I didn't care about anything. I'm like, well there's nothing there, I don't want to live my life feeling like a failure.

Summary

Feeling that they had been repeatedly rejected combined with the continual fear of rejection had a profound impact on feelings of self worth, self efficacy, and personal value of the participants. The rejection that they felt from loved ones and peers, whether intentionally directed toward them or not, fuelled feelings of anger and resentment. They began to reflect on the real or perceived rejection from others and gradually began to reject themselves as unworthy, unlovable, and unimportant people. In addition, they developed the belief that they had little impact on their environment or the people in it. The depth of the rejection was further compounded by feeling that their parents had chosen to attend to their own personal needs, and the needs of their spouse, rather than to the needs of the child. Paradoxically, rejection of others became a method of ensuring safety and personal protection. Paradoxically, rejection of others became a method of personal protection for some.

Betrayal

Rejection can be understood in varying degrees, in that we can reject someone's ideas by showing how those ideas do not hang together, or we can reject someone's advances by stating that we are not interested. But unfortunately we can also reject another so totally and so unconsciously that the rejection strikes the very heart of the person concerned. When this type of rejection occurs there is often an accompanying feeling of betrayal that is experienced by the one who is rejected.

All participants related their experiences within the context of feeling betrayed in a variety of ways. While Elaine and Janet identified the betrayal as coming primarily from family, Debbie's experience led her to believe that

betrayal would occur wherever she turned for assistance, reassurance, and understanding be it from friends, family, or society at large. Ryan, on the other hand, felt that betrayal came from the institution that provided the foundation of his spiritual faith.

Ryan's sense of betrayal was encountered through his church. As a child and teen, he had been a faithful churchgoer. He learned that God loved him unconditionally and would provide him with the strength to face life directly. As Ryan became increasingly aware of his sexual orientation, however, he became aware of the discrepancy between the message that God loved all of his people and the message that homosexual and lesbian individuals were evil sinners:

> I felt like the Catholic church which I attended with my parents betrayed me. I knew what the church thought of homosexuals and this guilt kept on coming on and you felt guilty and more guilty and more guilty about who you were.

Janet, Lisa, and Elaine each experienced their parent's choice of loyalty to a new partner as betrayal of parental responsibility to them and their siblings. Each indicated that they felt unable to compete effectively for the affection of their parent, and that they no longer felt secure in the knowledge that they were important contributors to family life. Each experienced feeling displaced and translated this into betrayal. Janet described the relationship with her mother during childhood in the following manner:

> So there was a kind of antagonistic relationship there in terms of her needing to choose me or him. That's exactly what it was. It was always her choosing him over me when I was younger.

Adding to the perception of betrayal, created by feeling displaced by the parent's new relationship, was the resulting change in roles within the family in order to accommodate the new relationship. For these three participants, the parent's new relationship also brought new children into the

household which resulted in the need to make adjustments in family functioning.

When Elaine was able, with the assistance of therapy, to make the disclosure to her mother about the sexual encounter with her stepfather, she anticipated receiving understanding, support, and love. She also anticipated that her mother would feel that the violation of the norms of acceptable behavior within the family would require immediate action and accountability. Counter to her expectations, the mother's initial response to the disclosure was hostility, rejection, and laying blame on Elaine. Elaine was left feeling confused, vulnerable, and rejected, but most profoundly, betrayed. After some time her mother indicated that she believed Elaine and made promises about the future that were not kept:

> I'll tell you, when she had said o.k. yeah, I'm leaving him and bla, bla, bla, it's going to be really hard and I'm going to have to move into a small apartment and we might have to live together to afford things. And I was thinking cool, really cool. This is a chance for us - meaning my younger brother too and whoever. For us to live together like a family - struggle but be together and really learn about each other and love each other. I was really excited with the thought of him [stepfather] not supporting her....I was thinking, right on. We're going to get back to the basic life. So that never happened. So that part, I was really excited about that. So that never happened of course and I was basically just really let down, betrayed.

Although her mother did leave the relationship for a short period of time, she shortly returned to live with her husband. Once again, choosing to remain in the relationship with her husband rather than take action to rebuild the family in a different way was seen by Elaine as a betrayal.

In order to justify her actions, the mother indicated that she was uncertain as to whether to believe that the sexual interaction had actually occurred. Elaine explained her reaction:

> Again I felt everything that I felt in the first place. Totally betrayed and she was dishonest and she didn't love me and how many other people had she told that I'm a little storyteller or liar.

As she continued to relate the sequence of events of her life, it became apparent that the betrayal that Elaine experienced before, but more importantly after, disclosing the sexual encounter to her mother, played a significant role in the development of a deep depression and the increasingly self-destructive behaviors that preceded her suicide attempt.

Betrayal played a major role in Debbie's life and over time she began to expect it in all the situations she encountered. She experienced her family as unable to meet her needs when her needs were at their most profound level. This she interpreted as betrayal. Debbie also interpreted the inability to deal with issues in an open and honest manner as lack of caring or disinterest. She felt that there were few ways in which she could behave that would generate active involvement from family members. Although Debbie denied that her attempt to take her life in her teen years was a method of obtaining parental attention, the lack of response after the attempt was interpreted as a betrayal and denial of her value in the family:

> I was really hurt that she didn't sit down and say, so by the way, why did you take all my pills? Why? Are your trying to commit suicide? Is there something wrong? You know, or did you just do it for fun type of thing? She never did try to ask me to find out why I would do that. She just punished me for it. So that really wounded me on top of the fact that I survived it which was disappointing and so that attitude of doom and gloom and betrayal didn't make me feel that I wanted to live after she did that to me. I was already feeling you know, my self-confidence was in the toilet to begin with. Yes, that was really hard, tough.

Debbie made a number of attempts to build friendships outside of the family in which she could disclose and discuss the events of her life. Whenever she turned to an individual outside the family for solace and understanding, events left her feeling betrayed once again. Her attempts to come to terms with the emotional abuse by one brother, and sexual interference by another, usually involved talking with trusted friends about the source and extent of her distress. However, because of the close knit ties between her family and her friends, in each case that she was able to disclose her life experience and the struggles that she faced, the friend

would become involved emotionally, and sometimes romantically, with some other member of her family:

> I sort of turned to her as a confident and rescuer and then she kind of ended up falling in love with him [brother]. That was really hard to take.

Partly as a result of the unrealistic expectations of the services that psychiatrists could provide, when Debbie sought professional help, even the psychiatrist acted in such a fashion that she felt betrayed, resentful, and cautious about obtaining further professional help. As a result, Debbie felt that no one was trustworthy as she had experienced betrayal regardless of where she turned for assistance, whether they were friends, confidantes, family, or society in general.

The lack of attention directed toward Debbie, Elaine, and Janet after their first suicide attempt in their early teenage years was perceived by each as a form of betrayal. The responses that they received included the message that they as individual children were the problem, not that the family had a problem, or the situation was problematic. Each felt that their parents should have cared about the health and security of their children. The type of intervention that could have remediated the larger issues that played a part in the suicidal behavior were not obtained and there was, therefore, no problem resolution. Regardless of whether it was building a more solid personal connection that improved the lines of communication, or obtaining professional assistance, no action was taken that would help in dealing with family and individual difficulties. In addition, the parent's lack of involvement reinforced the belief in each participant that, as children, they were uncared for.

Summary

The accumulated betrayals experienced by Ryan, Debbie, Elaine, and Janet had the impact on each of losing the foundation of their prior beliefs and behaviors. Lisa experienced one fundamental betrayal that she

struggled with, rather than repeated betrayals. As they each struggled to deal with difficult issues in their lives and repeatedly experienced failure at their attempts, a sense of insecurity and futility was fostered. They were each unable to find a meaningful or purposeful path through life and felt resource less. Betrayal was perceived by all of them to be the breaking of a fundamental trust, a trust that nurtured a sense of self through relationship. When they felt betrayed, therefore, the betrayal offended the very core of the person experiencing it. Each of the participants of this study repeatedly experienced either real or perceived rejection and came to understand this rejection as betrayal. Therefore, betrayal followed rejection in the interpretation of life experienced by these individuals.

Anger

Anger was used in different ways and had different functions for Lisa Elaine, Debbie, and Ryan. It was used as a defense of the self, as protection from both self inflicted pain and pain inflicted by others, and as a coping mechanism to deal with distress or upset. Sometimes feelings of anger were denied and altered to allow more acceptable emotions that could be expressed.

During her teens, Lisa was able to deal with her anger toward her natural parents in a contained manner. In her early twenties, however, as her difficulties compounded to include academic failures, inability to pursue the career of her choice, and lack of support from peers, the anger that she felt began to take expression in her family interactions. She began to express hostility toward her father:

> All the anger that I had built up for years towards both parents and for having separated like that -- for having not allowed me to see my mom, for my mom not coming to get me and fighting for me and that they [father and stepmother] had their sort of complete little family and they really tried to include me when I would bring it up to them -- something about well you guys have your own family and they'd say "You're part of this", but I never did feel part of it....There was a lot of emotions that I had repressed for a long time that kind of...that came out at various kinds of stages - stronger and stronger, would kind of

come out in various ways. Anger was kind of the strongest one I think.

Anger was used by Elaine as a motivator to provide the impetus for action although it tended to be self-destructive. In the absence of more productive or constructive coping skills, she used anger in an attempt to make changes in her life situation. Rather than lose control, generating anger made Elaine feel powerful and in control. Despite temporary feelings of power, however, her responses were a reactive protection against pain:

> I would cry when I was drinking but before that, I would never let myself cry. You want to cry, you wimp? Get angry, don't get sad, because it doesn't hurt. And I would literally sit there and make myself so angry that nothing hurt. Even physically....I'm almost crying and I thought fuck you. Get up. Don't you dare cry. He pissed you off, now get out of this situation. And I just got mad and it didn't hurt anymore. And really, right then I realized I can do anything now. As soon as I get angry, nothing hurts.

Anger provided a predictability that was otherwise unavailable. Life might feel 'lousy', but it was safe and stable. Elaine was angry with her family for their apparent rejection and betrayal of her as a child. She was fearful of making emotional investments in friendships and love relationships. Her need for love and care made her feel like a weak person which increased her level of anger at herself. She felt angry for not having more control over her emotional life and being unable to resolve her difficulties.

Because her anger provided a mechanism to distance herself from others, Elaine used it as protection from other people. Anger also provided a useful channel into which she could direct all her feelings of hurt, sadness, distress, powerlessness, fear, and betrayal. As a result however, she found that she was unable to productively evaluate, understand, and alter her emotional responses. Anger was the predominant expression of her life and obscured her ability to make effective changes. She refused to outwardly acknowledge her deep level of hurt. Anger seemed safe initially, but with time, instead of allowing her to feel powerful and in control, eventually it began to take and have control of her.

While Elaine embraced her anger and welcomed it as a protective and productive mechanism, Debbie found her anger difficult to admit to, or deal with, although she recognized that it is there. She used a variety of methods, including drug use, alcohol use, and self injury for physical release to avoid feelings of anger from surfacing. Her primary association with anger was emotional pain. Debbie noted that she often found herself feeling a number of different emotions at the same time that she felt anger which left her confused about what she was experiencing and feeling at a given point in time:

> The emotions are not cut and dried either. We may be, we can't even identify what emotions they are. We might only really focus in on one of them. But where there is anger there is usually hurt and frustration and pain and all kinds of things that add into what we feel as angry.... And then try to express that is a whole other ball game.

From Debbie's discussion of her anger, a pattern was identified in which she felt the emotion but did not allow herself to express it, preferring instead to attempt to make peace with the source of her anger. Debbie struggled between feelings of anger toward the brother that sexually abused her and her desire for harmony and solution to her distress with him. While she experienced and identified an inner rage about the incidents, she attempted to act in ways that would create an environment in which she and her brother could come to terms with what happened between them. She felt a sense of responsibility to heal the wounds that separated them:

> I showed him a page of letters that I had started to write him back when I was going through the ... clinic. It states that I guess I have a lot of anger towards you and stuff. But the rest of the letter was all like you know, I want to see both of us come out of this the other end. You know, like heal from it, try to get along and stuff like that. One thing that really made me angry though, was that I found, sort of through the grapevine in the family, that he denied ever molesting me to his girlfriend.

Debbie experienced anger toward herself because of her emotional struggles. However, feeling angry created guilt and vulnerability in Debbie

because of her belief that anger was an inappropriate emotion to experience or express to others. She discussed the perception that her anger was misdirected to "safe" people; herself, her husband, and her child. Loss of control was a fear that inhibited her expression of anger toward others:

> I've still got this anger so I'm needing to work that out: It's just that when I see them, like I mean, I've never gotten angry at George for all the shit that he put me through either....The other thing is I was brought up to not be angry that girls don't get angry or show anger. I'm sure lots of generations of women have been raised like that, socialized like that but, it's not nice to get angry. So I have a really hard time with anger. I'm good at getting angry at my husband and my child and myself. But I can't get angry at other people, like outside of that and especially my abusers. Like I just, I don't know how to do it and I'm scared and I am still intimidated by them.

Ryan's anger was directed toward himself as his struggle to deal effectively with his mood swings became increasingly difficult and he became more hopeless about controlling his disorder. Ryan began to blame himself, to see himself as a failure, and as incapable of managing his emotional life. As he discussed peer interactions, it appeared that he also felt angry about his inability to set and maintain acceptable parameters of behavior with his acquaintances. He frequently felt used and that his welfare was disregarded by others.

Although Janet did not identify anger specifically as an emotion that was meaningful to her prior to her suicide attempts, both suicide attempts followed minor physical assaults by her mother.

Summary

For Debbie, Elaine, Lisa, and Ryan, as the level of anger increased, so did the intensity of the levels of depression and sadness. Anger toward others for actual or perceived betrayal or rejection promoted the motivation for self-destructive actions for each of these participants. It appears that for each individual the intensity of anger experienced increased significantly just prior to the suicide attempt. While they had some sense of their anger, they did not express it or act on it overtly. Whereas each participant felt

anger toward others, the primary target of their anger was themselves, directed inwardly. While Elaine embraced her anger as a protective mechanism, the others avoided acknowledging the extent to which anger impacted their lives. Not knowing how to deal with anger provided some impetus for action. It was either embraced or rejected depending upon the individual perspective.

Alienation

Alienation from peers, from family members, and from the self were common experiences for the participants in this study. For all participants, with the single exception of Debbie, alienation from others and from self had been experienced since early childhood despite some attempts to make the child feel loved and accepted. While some adults did attempt to intervene and sooth the feelings of separation from others, these efforts tended to be minimal and had little impact. In addition, the efforts made did not address the primary source of the sense of alienation. Rather than deal with the underlying issues that resulted in feelings of alienation, the focus tended to be on external behaviors that could be easily identified, targetted, and fixed.

Although he participated in both group oriented and individually oriented activities as a child, Ryan related his longstanding feelings of being empty and alone in the world:

> Guys are supposed to be rough, tough, they're supposed to play hockey and you're trying to fit into this world...I just don't seem to find that niche and you don't know what's wrong with you. I guess I didn't connect with other boys.

His difficulties connecting with and building relationships with other boys lasted throughout his childhood and teen years. He interpreted his lack of conformity and connection to others as an indication that there was something inherently wrong with him, that some important and necessary part of himself was missing. His experience in childhood and adolescence was that of alienation from peers despite a strong desire to interact and to be liked by other children. He also felt alienated from the world at large

because of the self-interpretation of being different from others. Feeling alienated was a component of Ryan's earliest childhood memories.

As Ryan looked back on the events of his life, he described several situations where he tried to address the distressing issues of loneliness, isolation, and peer rejection in his life but in which the outcomes served only to further exacerbate and reinforce those very interpretations. In his later teen years, Ryan was looking for someone to trust and confide in, someone who would accept him for the person he was, someone who would be confirming and supportive, and, most importantly, someone non-judgmental. Ryan turned to a psychiatrist but was disappointed in the outcome of the relationship. This was similar to Lisa, Elaine, Janet, and Debbie who all sought professional help from psychiatrists but felt that they were not getting the support and understanding that they needed. Failure in their attempts to gain professional help further reinforced their sense of isolation and alienation from others.

Elaine's feelings of alienation initially grew out of feeling displaced when the family changed locations and the dynamics of the family changed with the addition of her mother's new partner and step-child. Elaine began to feel increasingly that her mother was inaccessible emotionally and unwilling to develop a healthy relationship with her children. Elaine turned to peers for support instead.

The feelings of being alienated were reinforced for Elaine when she moved from her family home and became involved in an unhealthy lifestyle. Elaine felt that she was carrying an ever increasing weight from compounding burdens and from carrying them alone. As her relationships were unable to alleviate her distress, and indeed added to her distress, her sense of alienation increased. As each relationship failed she became more and more convinced that she needed to isolate herself from others in order to protect herself. At the same time, she recognized that she was desperately unhappy and unable to function effectively alone. Her life was devoid of support or meaningful relationships. The alienation that she felt was longstanding, chronic, and seemingly inevitable. While her deepest desire was to have a relationship that would ground her and give meaning to her

life, over time she began to actively alienate herself from others through the rejection of offers of kindness.

Elaine indicated that her sense of alienation grew as she felt unable to discuss distressing issues with anyone that she knew. She felt deep distress because of the incident with her stepfather but could not talk about it. When Elaine finally made the decision to disclose the incident to her mother, she was unprepared to receive the response that she did. Elaine found her mother's response totally rejecting and alienating.

Even after her mother and Elaine had reconnected and attempted to construct a new relationship, Elaine needed to pretend that everything within the family was fine. No action had been taken to alter family interactions, however. Having to continue to live with the pretense that all issues had been resolved further increased Elaine's sense that her concerns and issues were insignificant within the family:

> I don't think she did anything, and then it was kind of like all forgotten -- know what I mean -- just shove it under the rug, you come over and you behave like you love this family and pretend to be happy and I hate the bastard and I have to walk into that house and talk to him. It's not so bad now, but then it was uncomfortable and not just thinking of that, but the trust is gone and he grosses me out and to think my mother is still with him, especially in a sexual way even makes it worse. So yeah, everything just kind of got pretended like it was normal, like everything was normal, nothing was ever talked about. We didn't settle anything and that was that.

As Elaine's desire and need for family relations grew, the family's inability to deal with relationship dynamics increased her sense of estrangement. As her sense of estrangement from family grew, so did her feeling of being estranged from the world, and so did her anger.

In a similar fashion to Elaine, Debbie's sense of alienation from the world grew as she felt the responsibility of keeping family secrets. As previously discussed, Debbie maintained very close ties with family, spending most of her recreational time with them. Like Elaine, she felt a personal need to come to terms with the sexual relationship with her brother, but felt constrained because of her fear of breaking up the family:

> Because if I told on John that would mean that I would break up the family that it would shatter -- I mean you have to remember that we grew up very very tight. We were very close you know with the [business] and whatever. It was us against the world because Dad was a fuck up and we, you know, sort of survived together -- for each other we had strength. So I figured that that would all be shattered if I told, which it likely would have been. I couldn't handle the guilt of that, so I couldn't tell and it was wrecking me inside.

The struggle that she experienced between trying to protect her family and working toward emotional health for herself contributed significantly to her feeling of being separated from the world.

Janet experienced alienation primarily from her family, particularly her mother. Having had little emotional connection with her step family as she grew up, Janet longed for connection with her mother, much as Elaine had. Janet's sense of alienation had been longstanding and often self-imposed as she distanced herself from personal involvement with peers:

> I felt alienated and alone all those years....I was searching for the closeness with my family. I've always wanted to feel like my mom loved me or that I sort of belonged somewhere I guess. We always moved around a lot and that's another thing. I never felt like I belonged anywhere.

Unlike the experiences of other participants, Janet's alienation from peers appeared to be primarily self-imposed as she actively chose to remain uninvolved despite their efforts to include her in activities. For her, alienation from peers was a protection from pain because of her conviction that friendships inevitably ended. In describing her life it became clear that although she was heavily involved in athletic endeavors, she always chose individual rather than group sports and did not attempt to develop friendships with others engaged in those same activities.

> I always felt like I was different in some way, that I never fitted in anywhere, I just didn't feel like I belonged anywhere. And I never understood why until I got older.

Janet felt that she must somehow be so different from others that she did not deserve love or care. Additionally, she felt a strong need to resolve family issues. Unanswered questions about why her father had failed to maintain contact with her following the divorce continued to foster the perception that Janet was an insignificant and unattached individual in the world. These feelings added to her sense of alienation as she felt she had no solid roots, no longstanding friendships, and no foreseeable future. Janet's interpretation of her life was that she had a past she would rather forget, a present that was unfulfilling and lonely, and a future that held little hope for change. Her sense of isolation from the world was a result of her sense of alienation from meaningful relationships.

Ryan admitted that he developed many relationships but that they lacked depth. He was so concerned about others' evaluation of him and tried to please to such an extent that opportunities to develop a more complete understanding of himself as an individual were lost. Elaine did not maintain relationships for more than a brief period and restricted them to men and sex. As her sense of alienation from others grew, so did her sense of alienation from herself. Janet attempted to replace the love and respect that she desired from her family with a love relationship that ended because of her inability to invest herself emotionally. Both she and Lisa were unable to replace friendships that they had relied upon through their school years. Others distanced themselves emotionally from Debbie because she was so emotionally dependent and intense that she demanded more that most friendships were able to provide. Few could handle the depth of Debbie's need for connection.

Alienation from parents occurred because of disruptions in family functioning, either through readjustment in accommodating a new partner or trying to deal with the mental health issues of family members. It also resulted from the inability to trust others. Experience had proven to each participant that when support was most urgently required it was denied by those who could provide it. In addition, conflicting messages were received that left the participants confused about societal expectations, norms of behavior, and the ability of people to support one another in times of need.

Expectations were repeatedly unmet.

Summary

For these participants, alienation was a long-standing, chronic, and inevitable condition that was perceived to be the result of a lack of support, primarily from family. As a result, four participants felt that they were not grounded in a significant and meaningful way that provided necessary meaning to their lives. Alienation was increased when these participants observed the treatment of other siblings by the natural and step parents. Injustice and unfairness was a routine observation and led to the belief that the family was not a safe place to be. The place that each of the participants perceived should have sheltered them from the world's problems was in itself a part of the problem as they felt separated from it.

Alienation was a slow and progressive process that had its roots firmly embedded in family relationships for Elaine, Debbie, and Janet. Ryan and Janet recalled alienation as part of their earliest childhood memories. They experienced an ever-increasing awareness of being different from peers which contributed to a growing sense of alienation. During middle to late adolescence, both were partially able to overcome their perceptions of alienation, but each returned to the state of feeling isolated from others in early adulthood.

Disappointment and emotional pain gave birth to a world view that served as the basis for subsequent action: protection of the self was primary. Distance provided protection. Alienating oneself from hurtful interactions achieved distance. Alienation was the inevitable result of decisions to severely restrict the type and depth of personal interactions.

Depression

Depression was a common element in the stories of each of the participants in this study. Ryan and Debbie not only experienced chronic depressive episodes first hand, but they also lived with fathers who suffered

from manic and depressive episodes. Elaine, Janet, and Lisa all experienced differing levels of depression ranging from Elaine's depression of several years to Lisa's depression of several weeks.

Ryan and Debbie both suffered the effects of a longstanding, chronic depression. They differed only in onset, which was early childhood for Ryan and adolescence for Debbie. Both had received psychiatric intervention that included medication and "psychoanalysis". Despite their attempts to control it, both began to feel that their struggles with depression were futile. While the lack of improvement in their mental health proved to be extremely discouraging and frustrating, Ryan continued his attempts to control his depression with medication and Debbie gave up in resignation. Ryan expressed frustration at his belief that the depression was conquering all his attempts to improve his life and felt thwarted in his efforts:

> You're doing everything right. You're growing in the right direction - you're going to school, you're getting an education, but you're depressed. And once again, it screwed you up when you were younger, it's screwing you up once again and you're going to the doctors to get meds and the meds aren't working and what do you? What the hell are you supposed to do?

Depression was "a double-edged sword". Ryan found that because he could not connect with others in a meaningful way, he became increasingly depressed. However, because he was depressed, he found that he couldn't connect in a meaningful way with others. He felt trapped. He also felt that no one was able to understand the depth of his despair or distress so his depression was experienced as isolating, which only increased the depth of his depression. As he related his life experiences, it became clear that he had suffered from depressive episodes since his earliest childhood:

> I remember locking myself in my room and crying and crying and the whole family being brought in.... But nobody understood. It's hard to explain but I was just so sensitive that things to them that seem meaningless to others- to me they just set me off.

The fear that his depression would overwhelm all aspects of his life

grew in prominence. In his late teens and early adulthood Ryan found that he was increasingly experiencing difficulty thinking in logical, rational, and productive ways. Typical of depression, he focussed primarily on the negative aspects of his life. He struggled to force himself to function effectively. Although he was able to function effectively for short periods of time, when depression overcame him, each episode was worse than the last:

> Your thought processes aren't working properly. You're frustrated because you're scared that you could have lost it forever. What if it doesn't come back and you're like this for the rest of your life? I guess that's like being blind, but for me, I didn't want to be a burden on others. Because a blind person can still move around, get around, they can still think. You're not thinking right now. Things aren't working.

Ryan became increasingly desperate as one medication after another failed to control his illness. His continual efforts to obtain therapeutic support from a psychiatrist failed to improve his ability to function. And although he continued to try to make improvements in his mental health, he began to experience a profound sense of hopelessness, helplessness, and finally desperation.

Compounding his depressed state was the internal struggle over his sexual orientation and personal identity. Ryan still wished that he could be heterosexual. As discussed previously, Ryan was constrained by a profound fear of being rejected by his family. Although he had an established peer group of gay and lesbian individuals, he had carefully kept them separate from other parts of his life and described himself as "living in two worlds". He felt that his value in the heterosexual world was based solely on pretense. As the internal pressure to disclose his sexual orientation built up, his desperation and depression increased to an unbearable level.

Ryan was aware of the elements in his life that fuelled his depression but that he was still felt able to control to some degree. However, he also acknowledged that there also appeared to be a strong biological component to his emotional functioning which he felt he had little to no

control over. Ryan had come to this realization through observation of, and comparison with, the struggles that his father experienced in dealing with his own illness.

Debbie also experienced many years of depressive symptoms beginning in her teenage years. Her academic performance, peer interactions, and family relationships contributed to a feeling of being incapable and inferior to others. In a manner similar to that of other participants, Debbie withdrew from interactions with others rather than seeking support. Recognizing her symptoms as depressive, Debbie's mother sought psychiatric assistance for Debbie in her mid teens. Following a diagnosis of clinical depression, it was recommended that she be removed from the home as the family dynamics and living arrangements served to exacerbate her problems.

Both prescription and street drug use escalated progressively throughout her junior and senior high school years. Most family and social interactions focussed on either drug or alcohol abuse. Debbie was also on a rigorous regimen of antidepressants during this period. She concocted "drug cocktails" which included both prescription and street drugs in an attempt to alleviate the anxiety and distress she continued to experience:

> I think the drug use and the alcohol use and stuff before that was to escape because it started as the thoughts of the incest started to surface more and more. The pain started to surface more and more so the drugs and alcohol were becoming more and more use so that I didn't have to feel the pain from the memories.

Over time, this method became less and less effective. Debbie's depressive episodes deepened in her late teens at which time she began to 'slash' herself to provide a physical release to her psychological pain:

> I know I was feeling pretty bad and feeling pretty down and I think that I wanted, I remember feeling that I kind of wanted to die but I didn't have the guts to do it that way [cutting wrists]. Like I didn't have the guts to cut my wrists deep enough and hard enough to succeed that way, but it helped to cut them....That went on for a few months, cutting the wrists and stuff, and I have kept all of the poetry and still have the

pages with the blood smeared on them.

She indicated that her depression helped create the perception that she was "trapped". Like Elaine, Debbie felt an ever increasing need to deal with the sexual relationship that had occurred with her brother. She felt torn between disclosing these events so that she could deal with them openly and honestly and protecting her family members from the truth. As her depression increased, she felt a diminished ability to deal with this distressing choice. Although she continued to be on antidepressant medication, she felt less and less capable of controlling her emotional state.

> If I couldn't tell and it was wrecking me inside, I figured I should just die and so I decided that. When I sat there I decided that what I wanted to do was take an overdose....I just couldn't take the guilt that I would be inflicting on everybody by breaking up the family and shattering the closeness.

Unlike Ryan and Elaine, who withdrew from interacting with others as their depression increased, Debbie sought out groups of people and potential "partying" situations. The more she partied, the more depressed she became; the more depressed she became the more she partied.

Debbie's depression was associated with fears; fear of disclosure, fear of rejection, fear of responsibility, fear of facing the future, fear that there would be no improvement in the future, and fear that there was no resolution to her predicament. Furthermore, she felt that she alone was the one with the responsibility of charting the course of family interactions. The guilt of this responsibility, especially when things did not go the way they were supposed to, was overwhelming.

Like Debbie, Elaine experienced extended periods of depression which lasted over several years. Similar to Janet and Debbie, her depression deepened as she aged. Unlike Janet and Ryan however, Elaine and Debbie used drugs and alcohol in an attempt to mask their feelings from themselves, and to provide relief from overwhelming and seemingly unresolvable personal issues. As Elaine stated:

> Obviously the alcohol contributed a lot to it but the alcohol came because of all the problems I believe, because I didn't know how to deal with them so I drank....As soon as I'd get a little bit stressed out, "Fuck this. I'm out of here and going to the bar to drink."

Elaine described herself as knowing that she was very unhappy but for the most part did not allow herself to identify the emotions she was experiencing. For several years, she tried to not allow herself to feel sad or depressed. She maintained as much distance from her emotions as possible. Whereas she felt sadness, despair, hopelessness, and helplessness, she refused to admit to herself or others that she experienced these emotions. The only emotion she identified with was anger:

> It was amazing. I just never let myself feel sad or think about things. But I was feeling really bad. I don't think I had many other emotions at the time.

Elaine, however, did recognize that issues needed to be dealt with before she could expect improvement in her life. Her awareness of her depression increased slowly over time. Like Janet, she knew that she was experiencing extreme emotional distress and that something in her life needed to change. Several months before her suicide attempt, Elaine sought help for depression. Unfortunately however, she lied to her doctor about her drinking problem, claiming that she seldom drank. Having obtained a prescription for an antidepressant, she nevertheless continued to drink, the net effect of which was to render the drug ineffective and served only to increase the darker side of the depression. As the intensity of her depression increased, she felt increasingly helpless in any attempt to implement effective changes in her life:

> But I just didn't want to be here. I hated everybody and I'm sure there weren't many people who liked me because I was a really horrible person. And I just didn't want to be here anymore - pretending everything was o.k. when everything was so fucked up....I hated it so much because I wanted to change but I didn't know how.

As she reflected on the experience, Elaine indicated that her sense of

isolation from others contributed significantly to her depression. Interactions with peers focussed on drinking and were devoid of opportunities to discuss meaningful issues. She had lost contact with family members, with the exception of one sibling, who provided support and understanding. When he moved to another city, Elaine found herself totally isolated and unconnected with others. She became increasingly unable to deal with the recurring thoughts and feelings that continually encroached on her consciousness, and withdrew more and more from interactions with others that could have provided meaning and support in her life.

Like Ryan, her isolation was a "catch 22" situation. The more she withdrew, the more isolated she became; the more isolated she became, the more she withdrew. Elaine turned her depression into anger and hostility, withdrew from others, and had difficulty controlling her thoughts, the combination of which finally led her to a sense of deep despair.

For Janet, depression was a condition that came and went with regularity in her late teens and early adulthood. With age, however, the intensity of her depressions increased. She noted that depressive episodes were often triggered by emotional or distressing events that occurred within the family context:

> I felt like a failure. It was like I don't want to be here, this isn't where I want to be in life....I was depressed since my first year in the program. It was just [pause] the feelings were there, the emotions were there, the sadness was there, the loneliness was there, everything was there but I guess just that one thing threw me over the edge, just made me feel like I'm in a really dark, dark pit and I can't get out.

Following the accumulation of several failures, including the termination of a long term relationship, academic difficulty which compounded feelings of hopelessness and pain, and feeling alienation and rejection from her family, life became a burden that was difficult for her to justify continuing:

> [It was] just that I wanted to end this black hole, the pain and stuff like that. I didn't care about anything anymore. I just wanted some way

> out and I was, like, well nobody's really going to miss me, they'll get over it, that type of thing. The world will still go on. [pause] Basically I wanted to end all the hurt and the pain. I thought well, there's really nothing for me here in this life - everything that I wanted to achieve I hadn't and I've always had to say goodbye to people so I guess maybe I wanted to say goodbye for good....I felt like I was grasping for air or just grasping for something, some sign of hope, but there was nothing there.

Unlike Ryan and Debbie, Janet described and understood her depression as emanating from the world that she lived in, rather than as arising from within herself. Since she perceived the accumulation of her problems to be beyond her control, she felt she had few resources to deal with the depth of depression she experienced. She indicated that once she was able to obtain the love she so strongly desired from her family, she was better able to cope with depressive feelings when they occurred.

Lisa's depression was similar to Janet's in terms of precipitating and contributing factors; failure at school, career implications of that failure, distress about ongoing family difficulties, and the lack of a supportive peer group. Unlike Janet, however, the progression of the depression was slow and cumulative, and she experienced only a short period of severe depressive symptoms that interfered with her daily functioning.

Nevertheless, Lisa's recollection of her experience was that although mildly depressed for some time, severe depression overtook her quickly. She became unable to control her thoughts or emotions and retreated from usual interactions with family and friends. In response to this Lisa isolated herself in an attempt to pull herself together emotionally. Like Ryan, she began to believe that she could do nothing right and became extremely self condemning.

Lisa indicated that she was afraid of admitting to being depressed and suicidal and for asking for support and assistance because she felt that this indicated weakness of personality. At a time when she was struggling with a number of major issues, she did not want to acknowledge her perceived weaknesses. In her mind, a request for help would require the admission that she was "a total failure" as a person and was unable to do

anything correctly or well. Realizing that she had few resources to call upon to improve her situation, Lisa decided that ending her life would be the best and most appropriate option.

Summary

Depression of various intensities played a crucial role in the decision of all the participants to take their own lives as adults. Few recalled the influence that the depressive episodes had upon their decision to attempt suicide as adolescents. The severity of the depression as adults ranged from mild to severe, and each individual attempted to overcome their feelings of depression in ways that proved unproductive.

Depression appeared to be a constant life partner for four of these participants, although the intensity varied over time and with each individual. As issues remained unresolved and new tasks were added to their emotional loads, each found themselves less able to develop or implement resources that would be helpful. Separation, withdrawal, and alienation from significant others tended to contribute to the depth of depression. As depression increased, each reacted; the action taken would not alleviate, but rather tended to exacerbate, the depression. As failures accumulated on top of previous failures, issues were seemingly unresolvable, and life became a larger and larger burden, eventually too heavy to carry. Each participant moved through depression from sadness to despair and both internal and external factors contributed to this progression. The future held no foreseeable change.

Control

Suicidal behavior is often interpreted as a form of attempting to control others, used by people who experience extreme levels of anger, despair, and futility. Four of the participants in this study disclosed their sense of desperation -- life for them seemed hopeless as it unfolded, and there seemed to be no possibility of change. With time they came to believe

that their struggles were inevitably unsolvable, but it was also clear to each that a change was absolutely necessary. Change could only be achieved when one was in control; therefore, control was absolutely necessary.

Elaine's family experiences and early intimate relationships fostered the impression that she was unable to control the quality, direction, or outcome of her interactions with others. Her intimate relationships were characterized by physical and mental mistreatment with individuals experiencing major life difficulties themselves. Sexual interaction became a tool to obtain, albeit temporarily, connection and affection from others. While her sexual interactions initially provided control in life, over time, Elaine began to feel used, valueless, and objectified. She realized her lack of ability to constructively take control of relationships or herself or to meet her need for connection in a more productive manner.

The longer her needs for love and care were unmet, the more desperate she became for control. Elaine discovered the use of her anger to set and maintain limits with others, allowing her to experience control in a new manner. She expressed anger to everyone she interacted with; co-workers, family, drinking companions. As previously discussed, Elaine found that converting hurt, or sadness, or fear, to anger provided her with the motivation to continue living. Elaine recalled the precise moment when she realized that control was possible for her and that she could alleviate her sense of being victimized which had been such a predominant perception for most of her teen and early adult years:

> And I just got mad and it didn't hurt anymore. And really, right then I realized I can do anything now. As soon as I get angry, nothing hurts....Don't let yourself get sad, get angry.

Alcohol and drugs were used as methods to provide control although they fuelled her rage. Initially, they provided an escape from unhappiness and were associated with pleasant interactions with others and forgetting one's troubles. Over time, however, this changed. Eventually alcohol, rather than providing control, took and held control. Elaine indicated that she turned to alcohol because she did not know how to communicate with others

or to deal effectively with her problems:

> If you can't communicate, all that shit stays inside of you and getting drunk doesn't fix it. You let it out a little bit and then it's still all in there because you just did something else to make an ass of yourself that's going to make you feel bad. If she [mother] would have talked to me and taught me how to communicate good feelings or bad feelings, that would have made a difference. But you weren't allowed to be out there and be angry or be sad.... You just shove all that shit inside and be a happy little girl. So I kept doing that.

Alcohol fuelled her anger at herself and promoted the perception that the cycle was unending. Elaine drank because she felt badly. She acted out when she was drinking. She drank because she acted out and felt badly.

Elaine disclosed the sexual encounter with her stepfather in an effort to take control of her diminishing emotional health. She believed, and was supported by her therapist in the belief, that disclosure would allow for constructive dialogue to occur giving her control of the future. While she thought she was attempting to take control of her life, in retrospect, Elaine realized that she was actually looking for support and acceptance. Following the disclosure and subsequent rejection and betrayal by her mother, Elaine felt that she had completely lost any chance of constructing a new reality for herself. She had lost all possibility of controlling her life.

It was when Elaine acknowledged to herself the level of despair, hurt, anguish, betrayal, and rejection she felt, that she attempted to take her own life. She recognized that her efforts to control and direct her life had actually been futile and that the changes required to continue living in a new and different manner were unavailable. At that point, Elaine felt completely overwhelmed and helpless, realizing the depth and extent of her emotional state:

> I just wanted to die. There was so much hate and anger and I just wanted it all over. I wanted to die.

Ryan felt that he had very little control over his environment or even over his experiences of his environment, a perception that originated as a

young child. He saw his lack of control as being different from others who appeared to have control and began to perceive of himself as defective and ineffectual:

> It was everything happening....being sensitive to everything, not being in control of your emotions, I guess, not being in control of your life and I guess I just had it. I thought if life is just going to keep on going like this, this isn't normal.

As he passed from his teen age years into his twenties, Ryan's perceptions of being socially inept, feeling inferior, and feeling helpless and defenseless against himself and others were reinforced.

Despite his attempts to make changes in his life and lifestyle, Ryan felt as if his world was caving in. He could not understand why his life always felt as if it was falling apart. He felt that he had no control over his increasingly deep depression and anxiety level. When he began to experience his body as not being his own, it compounded the anxiety he already felt about his personal identity and his ability to control his manic and depressive symptoms. His belief that the future held no promise for him was continually being reinforced:

> What comes up next might not be as nice as what's already been passed to you now. That's happening to your own body and you get damn scared when your mind processes are out of control...everything starts going fast, and I guess you're not in control of your body. This isn't your body. It's someone else's body. Might as well just get rid of it. If you can't do the things that you want to do and your body's just out of control...maybe it's just easier to take the soul out. I never saw it as a selfish process what I was doing. I thought it was the best and the right thing at the time.

Ryan also struggled with the idea that his life would be at the mercy of the effectiveness of his medication. His inability to function effectively without medication reinforced his perception that there was some fundamental flaw in his person and character. As he increasingly perceived loosing any chance for self control, he began to experience an intense sense of desperation -- that life was impossible without a major change but that

change was impossible. Ryan described his understanding of control as meaning having a balance in life. He saw that others were able to achieve this but felt that balance was not a realistic expectation for himself.

Unlike Ryan, Lisa's perception of lack of control originated from her perceptions of what it meant to be a success or failure in the adult world. She had a well formulated career orientation. While she felt a strong need to gain control of her life, she could only perceive of this occurring through obtaining a good education in a particular profession and proving to others that she was a worthy individual. Janet also experienced the same sense of needing to gain control and proving herself valuable by "being a success in life". Both discussed their fear of failure and how perceived failures would reflect on the value they placed on themselves and on life. Both Janet and Lisa believed that a good career would solve most problems and dissipate the feelings of anger and rejection they felt towards their respective families. Lisa stated:

> I had placed really high expectations on myself and I figured that if I wasn't meeting them then I was a failure to myself. I was a failure to them [family]. What was the point anyway? I wasn't going to--I wanted to get into occupational therapy and I couldn't get in and then I saw unemployment, I saw well there's not really a future anyways....And I suppose the career drive -- a big part of that was maybe having a place to fit in. At least there was something that I could control -- that I could have. And then I realized I couldn't control that. I could work really hard at university, I could work really hard to get this career and I couldn't get that. So there wasn't really anything else. There wasn't anything else to control, just to call my own.

Janet also interpreted being successful as meaning being in control. Without control she could not be successful and without being successful she could not be in control. As Janet moved from one university program to another, rejecting each because they were not suitable for her, the sense of control she had experienced at the beginning of her university career quickly dissipated. She recognized that by making a definite career choice, she was attempting to prove to herself that she was in control of her life. The search

seemed endless.

Janet understood that she was unable to exercise control of her relationships within the family directly, but felt that obtaining control through success in the world-at-large would result in family acceptance and improved relationships, her ultimate goal. She believed that once she had proven her worth, the family would recognize her value and interactions with family members would improve as a result of her success. Then she could experience the control she longed for.

Debbie believed that she had never had control of her life, except when using artificial means. Debbie's depression served as a means of controlling her living arrangements and family interactions in her mid and late teens. Her depression became the catalyst that created action and change in her life. In addition to contributing to her depression, Debbie's fear of disclosing the sexual intimacy with her brother deterred her from taking control of the situation to allow herself to heal:

> Like I just, I don't know how to do it and I'm scared and I'm still intimidated by him.

Because she knew that once she disclosed the abuse the family situation would be totally out of her control, she tried to control her understanding of her own participation in these acts. She continued to function within the constraints of unspoken family rules:

> This not talking and not acknowledging things drives me bananas. I mean I've lived with it my whole life and I don't like it anymore. It doesn't work.

Debbie made various attempts to gain control of her life including psychiatric intervention, use of prescription and street drugs, use of alcohol, and attempting to be emotionally independent, all of which proved to be futile. Rather than receiving supportive therapeutic assistance that allowed her to openly discuss her experience, Debbie found herself with a psychiatrist that all members of her family used. Therefore, even in a seemingly helping environment, she felt the need to protect her family and

constrained in dealing with issues. As was Elaine's experience, while drugs and alcohol initially provided a method of taking control of pain, within a few years, drug and alcohol use became the source of additional pain, no longer a control, but rather controlling. Debbie's attempt to create her own life and distance herself emotionally from her siblings resulted in feeling alienated and alone regardless of the fact that she had regular contact with peers.

Debbie did make attempts to discuss her distress with friends and seek support through them. Her first attempt at disclosure occurred when she initially moved away from home while her second attempt occurred prior to her second suicide attempt. In both these instances, she experienced betrayal when these individuals later became romantically involved with her siblings. Debbie learned that her lack of control in life included being unable to trust a confidante or friend to remain loyal.

When control of her thoughts and distress were conceived of as impossible to alter, Debbie gave up her attempts to find effective methods to control her life. In her experience, whatever strategy she used, whatever individual she relied on, whatever action she took to move toward emotional health, failed her.

Summary

For these participants, acquiring and maintaining control of their lives appeared to be a necessary but impossible goal. Each had tried a variety of methods to acquire control and were acutely aware of where they were unsuccessful. As the sense of having control eluded them, frustration and desperation grew. Emotional pain increased to an unbearable level. Life seemed to have them by the throat and they felt defenseless and completely vulnerable to attack.

Betrayal and rejection exacerbated their perceived lack of control. Betrayal was experienced from family, from peers, or from both. Experiences of betrayal added to the belief that control of one's own behaviors and life were impossible to attain. A growing sense of hopelessness and futility ensued. Rejection, whether real or perceived, and fear of rejection by family

played an important role in the feelings of diminished self worth or lack of personal value. The combination of betrayal and rejection appeared to have a significant negative impact on the feelings of personal value, worthiness, and ability to view life from a positive perspective.

These participants experienced an accumulation of distressing life events that compounded with time. They were unable to deal with and find resolution to one issue before another presented itself that required additional emotional energy and attention. The issues primarily involved interpersonal difficulties with family and with peers, unresolved feelings of distress, and desperation over the realization that changes were necessary for an improvement in life. Changes seemed unattainable. Life was meaningless and unbearable.

The suicide attempt was precipitated by deep-seated feelings of rejection, betrayal, anger, and alienation, which contributed to depression and the belief that life was uncontrollable. The action taken to end their lives was a response to the overwhelming need to obtain final resolution to their struggles. The events, feelings, and thoughts that had preceded this decision were based on an increasing inability to cope with life's difficulties and led to life becoming conditional.

The suicide attempt gave each a sense of mastery over their lives through control of living or dying. Four participants, excluding Lisa, had the means readily available. Each had made provision for a possible future suicide attempt by storing prescription drugs. The decision to make the suicide attempt was done at a time when each was experiencing a sense of desperation and complete lack of control. Rejecting life rather than waiting for what was perceived to be the inevitable and ultimate rejection by others was the method by which control seemed possible. The suicide attempt was made, therefore, as a way of resolving their interpersonal difficulties and internal conflicts.

Chapter Six

Discussion

The purpose of this research project was to examine the suicidal process that young adults had experienced prior to making attempts on their lives. Participants were interviewed and encouraged to present their life experiences in their own words and using their own structure. Throughout the following discussion, the findings are examined within the context of the five participants and no attempt to generalize to a broader population has been made. However, it is appropriate to note on the basis of this small but in-depth sample, the similarities and differences between the literature and the descriptions of the phenomenon as presented by these participants.

The questions that were investigated in this study included an examination of the psychological reality of each participant prior to their suicide attempt, an exploration of individual psychological needs, and reflections on the environmental factors that may have impacted individual decisions to attempt suicide. An attempt is made to elucidate these realities within the context of the research findings. During the process of analyzing each of the interviews and discussing the interpretations with each participant, it was difficult to discuss issues in isolation. From the perspective of these participants, emotion, cognition, and behavior were intimately interwoven, contributing to an integrated whole of experience. The tight interconnection between external and internal reality that each perceived and revealed was striking.

The participants of this study experienced private journeys as they explored life in a search for self, for self acceptance, and for acceptance from significant others. The end result of this process led not to personal fulfillment to which they had aspired, but rather to personal rejection. Their ultimate rejection, that is the rejection of the self and life, followed an accumulation of disruptive life experiences.

Research Findings

Through personal interviews an attempt was made by the researcher to explore and to gain insight into the psychological reality of the participants prior to the suicide attempt each made in their early twenties. An expanded understanding of the thought processes, emotions, and behaviors was pursued through discussion in an effort to illuminate this profound experience. Participants were encouraged to reflect on their life experiences and explore the issues that they felt had an impact on their decision to make a serious attempt to end their lives. Through an analysis of the data, themes were identified that were common to the experiences of all participants. Five major findings resulted from this project and were compared and integrated with the existing literature. Each is discussed at length in order to demonstrate the consistencies and inconsistencies with the general body of knowledge about this field of suicide and suicidal behavior in young adults.

A brief outline of the major findings of this research that contribute to a more global body of suicidal knowledge is outlined below. A detailed discussion of each of the major points of this research which includes an integration with the literature follows. The major findings are:

• Contrary to the crisis model of understanding suicidal behavior as a response to a particular situation or circumstance, contemplating suicide and deciding to end life was a slow and progressive process that resulted from an accumulation of cognitions and emotions which occurred over the course of several years for these participants. Attempted suicide was not representative of a crisis situation per se but rather was a decision reached after each individual experienced years of distress.

• Loss played a significant role in contributing to each participant's perception that life held little meaning or significance. Losses were cumulative with the most profound losses having occurred during childhood. The impact of one loss was exacerbated by another loss before resolution or

recovery was possible from the earlier events or feelings.

• Connection to others or to something important in life, and the ability to express connectedness through interaction or communication, was identified as being of primary importance in giving meaning to life. Accumulated losses provided the framework within which the possibility of connection to others became an unattainable goal and contributed to the erosion of connections with others, primarily with valued family members.

• Seeking control of pain was an internal struggle whereas seeking control over life required a balance of inner control and control of external factors. Attempts to control external situations and forces were used to obtain internal control in the belief that once external factors were different, internal reality would change. Control was considered imperative for successful living, however it seemed unattainable.

• Developmental research appeared to inadequately address the emotional processes and issues that impacted the lives of these individuals. Emotional functioning, a key process which served as the foundation upon which all other developmental tasks appear to have been undertaken in this important transitional period, should be more completely explored.

Integration with the Literature

Perspective of Suicidal Behavior

Little attention has been given to understanding suicidal lives in a meaningful way (Lester, 1994; Maris, 1981; Shneidman, 1985), and particularly rare is the research from a global perspective into the suicidal thoughts, behaviors, and affect of young adults (Leenaars, 1997). To develop a richer understanding of the phenomenon, it is important to acknowledge that psychological, interpersonal, situational, and existential components contribute significantly to the interpretation given by an

individual to their life experience. As such, suicide and suicidal behavior must be understood as multi-determined, rather than in a (unitary) causally determined manner (Gibbs, 1990; Hamdi et al., 1991; Hendin, 1991; Robins & Kulbock, 1986; Shneidman, 1985).

Some researchers have called for their colleagues to move away from the unitary causal focus in studying this phenomenon (Gibbs, 1990; Hendin, 1991; Leenaars, 1997; Robins & Kulbock, 1986; Shneidman, 1985). There continues to be a tendency to examine only components of suicidal behavior and not the whole person and their contexts within which interaction with the world occurs. This leads to a reinforcement of the societally sanctioned belief that there is something inherently wrong with suicidal individuals. Indeed, consistent with Maris (1981) the participants in this study grew to believe that they were completely incapable of dealing with the stress and distress of their lives and that resolution to their problems lay solely within themselves. Since they were unable to resolve their problems and felt that they were failures, they felt inadequate as human beings (Hendin, 1991). Accumulated failures contributed to viewing themselves and life negatively (Hughes & Neimeyer, 1990).

There are two important perspectives of suicide and suicidal behavior that impact on the understanding of, and intervention with, suicidal individuals (Pulakos, 1993). Suicidal behavior can be understood as a crisis, in that a particular precipitating event has resulted in the attempt to end one's life. The other perspective posits that suicidal behavior is acquired over time, is integrated into a repertoire of coping mechanisms, and results from disruption or instability due to the lack of resolution to underlying personal issues and problems.

It was clear that these participants did not become suicidal from a specific identifiable event or situation, but rather had experienced repeated stressors that they were unable to cope with effectively (Diekstra, 1989; Kral, 1994). As the level of stress increased, strategies for coping were slowly eliminated as they proved to be unsuccessful time and again. No new strategies were generated, however, to replace those that had been eliminated. Self-destructive behaviors were developed as coping

mechanisms (Maris, 1981; Smolak, 1993). The participants had few resources from which they could seek support or from which they could generate new or innovative coping or stress management strategies (Carrigan, 1994; Heikennen et al., 1994). As a result, a seemingly unimportant or recurring event usually precipitated the suicidal act itself. Therefore, becoming suicidal was a process, not an impulsive decision. Each individual felt that they were unable to adequately or effectively cope with what life presented them with; their resources were exhausted and they felt repeatedly pushed beyond the brink of endurance (Maris, 1981; Shneidman, 1985; 1993a; Smolak, 1993).

As they attempted to deal with depression, hopelessness, and dissatisfaction, self-destructive mechanisms were developed in an attempt to alleviate emotional distress. These behaviors, rather than leading to problem resolution, increased the stressors and difficulties experienced in life (Hughes & Neimeyer, 1990; Maris, 1981; Smolak, 1993).

Consistent with prior reported research (Beck, 1986; Beck et al., 1975; Beck et al., 1985; Beck et al. 1993; Hawton, 1982; Maris, 1981; Shneidman, 1985; 1993a; 1993b) the participants in this study attempted to alleviate severe psychological distress through their suicide attempts. More than experiencing depression and hopelessness (Beck, 1986; Beck et al., 1975; Beck et al., 1985; Beck et al. 1993) these individuals reported feeling despair (Hendin, 1991; Shneidman, 1985). They had exhausted all emotional resources. As the pain of life was unresolvable, suicidal behavior made sense to each participant as a statement about the value of life.

The importance of understanding the psychosocial factors that influence suicidal behavior and the interaction of those factors with the personality and affective reality of the individual, cannot be underscored enough. Suicidal behavior resulted from a process, not an event. In order to understand the process that lead to being suicidal, it is imperative to look at the cognitive, affective, and social components of each individual which had such a dramatic impact that suicidal options became viable. While understanding the affective states of the young adults helps to clarify and structure the cognitive state (Hendin, 1991), a richer understanding of the

phenomenon can be obtained only when the experience as lived by the individual and more global perspectives provided by outsiders are heard and integrated.

When studying sensitive areas such as suicidal ideation, behavior, and attempts, it is necessary to incorporate both the personal lived perspective plus the observer perspective. Understanding the inside view, the sense of the experience of wishing to die, is a neglected aspect of this research area. Our knowledge of the phenomenon would be enhanced by allowing the richness of the emotions and cognitions of personal experience to combine and complement objective explanations. During the interview process it became clear that with improved emotional health, the participants began to view their situations from multiple contexts and to understand reciprocal processes. This approach in the research community would result in a deeper, more comprehensive understanding of suicidal behavior in young adults, which could provide the basis for successful intervention programs and therapeutic strategies. It would seem that a broader perspective that allows for the clear understanding and integration of personal suicidal experience with research findings is a viewpoint to which more observers should be encouraged to aspire.

Loss

The impact of loss experiences in adolescence has received interest in the research community (Hamdi et al., 1991; Heikkinen, Aro, & Lonnqvist, 1994; Hendin, 1991; Morano, Cisler, & Lemerond, 1993). However, results concerning the impact on young adults seemed unavailable. Repeated and cumulative losses that left the individual feeling isolated and lacking in emotional support was common to the lives of the individuals in this study. Both actual and perceived loss were identified and included loss:

- of family,
- of position as a valued member within the family,
- of security through repeated geographical moves which resulted in the loss of extended family or social support,

- of love of a parent,
- of confidence in their ability to control the events in their life,
- of a sense of belief in themself,
- loss of important relationships outside of the family,
- and of a sense of security and certainty in the value of life.

Not only did the losses occur in childhood but also in adolescence and early adulthood. However, disruptions experienced in childhood and early adolescence were identified as the most distressing and had significantly more impact than those experienced in later adolescence and adulthood (Maris, 1981). The losses experienced in adulthood were often precipitated by self-destructive behaviors. Anger, frustration, and lack of self-worth seemed to fuel the intensity and frequency of self-destructive behaviors, whether they were enacted as withdrawal from others or increased drug and alcohol use. The frequently experienced reaction by others to self-destructive or self-harm behaviors was distance. Increased distance, interpreted as another rejection, added to these participants' awareness that the quality of their interactions was deteriorating and exacerbated their sense of alienation. When attempts were made to reclaim control, another loss would usually result.

As losses accumulated, the sense of disruption, isolation, and depression resulted in difficulty finding a reason for living and eventually to a sense of desperation (Hendin,1991). Disruption and isolation were significant contributing factors to these participant's move toward desperation. To love and to be loved are considered necessities for healthy development, as is the need to feel secure in one place in the world (Bowlby, 1982). Feeling accepted, needed, and loved were identified as the missing elements of these lives, consistent with Bowlby's theory, therefore their experiences of love were severely restricted.

The profound impact of life disruptions resulted from the creation of both personal and situational insecurity. Experience had taught these participants that no one could be completely relied upon because eventual rejection or betrayal was inevitable. Disruptions created an ambiguous and

unpredictable environment within which each individual had to navigate.

Failed attempts to problem solve were experienced as losses. Solving problems effectively is a result of developing skill over time (Connell & Meyer, 1991). Although they had each made various attempts at resolving pressing issues, most attempts had been unsuccessful, partially as a result of the nature of the issues that were being dealt with. After repeated failures, these individuals were unable to determine their strengths and weaknesses as well as their boundaries of what was and wasn't acceptable. They each lacked confidence in their ability to handle difficult situations. The complexity of problems became increasingly difficult to handle. As supported in the research investigating adolescent suicide attempters, the problems were perceived to be out of their control (de Man, Leduc, & Labreche-Gauthier, 1993). Lack of support, lack of encouragement, and lack of understanding in facing problems was demoralizing and tended to be interpreted by these individuals as lack of caring by others which then translated into perception of self as weak, inferior, and valueless.

Each became convinced that resolution to issues of concern was an impossibility and effort to reach resolution was futile. Resolution of one problem would only create another, probably larger, problem. For example, two participants felt that it was their responsibility to attempt to maintain the family structure and status quo. Both felt responsible in large part for the problems of their family and believed that disclosure of sexual relationships within the family would result in breaking it's outwardly cohesive nature, creating an unstable environment. The disclosure of abuse would create heartache and distress for other family members, and there was no protection once the secret was known. Therefore it was safer to keep the secret than to risk being rejected by those from whom love and acceptance was so desperately sought.

The emotional difficulties that these participants experienced had grown over a number of years and resulted from rejection, a lack of nurturance and caring, and cumulative losses. Loss was accompanied by anger, rejection, betrayal, and eventually alienation. Over time, one problem was layered over another as they moved from childhood into adulthood. As

they compounded, there was an increasing tendency to see the self as weak, incapable, ineffectual, and unable to handle emotions. To function effectively as an adult, it is important to learn to deal with the wide range of emotions in an constructive manner. These individuals learned that emotions of fear, sadness, and anger, were bad and needed to be avoided, repressed, denied, ignored, or hidden (Hamdi et al., 1991; Diekstra, 1993; Diekstra et al., 1989). They blamed themselves for the inability to deal with emotions; blamed themselves for the problems they were experiencing because of their inability to find resolution to their distress.

Coping became increasingly difficult, until most experienced feeling overwhelmed and defeated. Defeat fostered desperation and despondency. Continuing to struggle to overcome difficulties was futile (Maris, 1981; Shneidman, 1993a). These individuals felt that they could not face another problem, another rejection, another day, another moment of pain, and they needed to find a solution that released them from the distress of no hope of improvement or change. In an admission of defeat, suicide became the last available option.

Connection and Communication

Interview Process

The participants used the initial and subsequent interview process to review and reflect on their lives and their decisions about suicide. They discussed the beliefs and personal transformations they had undergone as they moved through the stages of their journey toward death rather than life. This process is well documented in the literature (Colaizzi, 1978; Frankl, 1959; Van Manen, 1990). Meaning includes identifying both perceptions and interpretations about both life and death (Frankl, 1959; Hendin, 1991). As these participants drew closer to the decision to take their own lives, they were struggling with what meanings their lives held, for themselves and others, in addition to the meanings that their deaths would have. Each searched to understand the purpose of their intense struggles. Sometimes

they were fully aware of the issues that created distress and why and other times they only had a vague sense of what was disturbing them but were unable to identify exactly why or how.

Each participant spontaneously tried to answer the "who", "what", "where", "when", and "why" questions in an attempt to convey the meaning the profound experience had for them. This process is consistent with Frankl's (1959) premise that one of the most basic needs of humans is to give meaning to one's life and experiences. The stories of each of the participants were compelling, sometimes overwhelmingly filled with pain, distress, struggle, and desperation. Few observers, if any, recognized the struggle as it unfolded. Acknowledging the dissonance between personal experience and external perceptions is essential and has important implications for effective family and individual interventions (van Manen, 1990).

Interestingly, each participant indicated that the act of relating their experience and feeling heard was very helpful in their quest for a deeper understanding of their own journey. Three participants indicated that by relating their experiences in the interviews, they came to realizations and understandings of their behaviors that were new to them and that helped in the process of constructing more positive meaning around their experience. All participants discussed the need to talk about their experiences with individuals who would not condemn them. They felt the need to explore their understanding, not only within the context of their actual suicide attempt but within the context of their total life experience. They indicated that it was not enough to discuss targeted events or situations. Each needed to be able to discuss their experiences within their whole life stories, which made a difference in how they viewed their actions and decisions.

Connection

As individuals take on previously unexplored roles and responsibilities in life and engage with the world in a new and different

manner, the meaning and importance of personal connection changes. Lack of connection throughout adolescence and into early adulthood was a fundamental experience for these participants. Research in areas of coping strategies indicates the importance of support systems and how connection with others helps adolescents to cope during their teen years (Botsis, Soldatos, Liossi, Kokkevi, & Stefanis, 1994; Connell & Meyer, 1991; Kralik & Danforth, 1992). However older adolescents and young adults in their early twenties are not specifically identified or differentiated in these studies. What had been perceived to be satisfactory relationships in adolescence may no longer provide the necessary support required in young adulthood. Therefore it seems important to examine connection in young adulthood, a period of major life transitions.

Through their stories, participants re-iterated their need to feel connected to peers and family; to feel cared for and valued; to feel heard and validated; and to have a place to belong. Although each identified the need to feel loved and accepted as being of primary personal importance, the alienation and abandonment that each felt was clearly evident. A long series of emotional and cognitive experiences that included hurt, sadness, anger, and distress contributed to each individual's perception that they were not only separate, but also separated, from others (Cutrona, 1990; Maris, 1981). As issues remained unresolved, disturbed and disturbing feelings and emotions developed. Unresolved feelings, when acted upon, further alienated those who had previously withheld their love and attention. The reciprocal nature of interaction within relationships led to increased frustration and alienation.

Acting out of pain and anger eventually functioned to create further distance between each participant and those they longed for connection with. Offers of assistance extended by peers who could have provided support were often rejected out of anger. Each participant indicated that meaningful offers of support could have been provided by family members but were withheld. Support from family was urgently required and were the only offers that would have been seriously considered at the time of their distress. Eventually peer offers of support were withdrawn following

repeated rejection which increased the participant's sense of isolation.

As their sense of alienation grew, each participant attempted various methods to engage others in their lives and implemented a variety of coping strategies in attempts to deal with their failure. Attempts were rooted in anger and hostility rather than co-operation, and therefore usually produced results opposite to those intended. Lack of communication and miscommunication, which will be discussed further in the following section, were common. Alienation was increased rather than diminished which further deteriorated emotional bonds. For some participants, alienation eventually became the chosen method of protection from others although a strong longing for meaningful interactions with others remained.

Whereas peers had often provided at least minimal support in adolescence, the participants indicated that poor peer interactions in adulthood contributed to a feeling of separateness. They lacked meaningful work and loving connection with others (Maris, 1981; Shneidman, 1993). Those who had experienced a supportive peer group in adolescence found it difficult to replace once the network was no longer available. Support networks that had resulted from school and extra curricular activities disintegrated as individual paths diverged leaving friends and friendships behind. For the individuals who had not experienced peer support in adolescence, it was difficult to establish meaningful relationships.

Family attachment typically plays a strong role in promoting healthy development and positive self esteem in childhood and adolescence (Bowlby, 1969; Erikson, 1968; Maris, 1981). In relating their lives, these participants recalled primarily negative features of family interactions which were characterized by unpleasant interpersonal relationships, invalidating attitudes of parents toward children, lack of care and concern, and frequent upheaval or disruption. Safety and security through a sense of belonging, which typically provides the foundation for healthy emotional development, was minimal. Family environments were characterized by trauma and multiple problems. Emotional needs not met within the home had an impact on perceptions of personal value, contributed to poor social support networks, and led to higher levels of stress (Cutrona, 1990; Maris, 1981).

These participants experienced apprehensions about revealing their true identities and struggles within the family because of perceived risks to their personal integrity if they did so (Erikson, 1968). Revealing personal struggles felt risky because of anticipated negative responses within the family context that would function to widen the gap of personal connection, resulting in greater interpersonal instability and further isolation from support. Time and again these fears were proven to be founded in each participant's reality. At the times that they felt most in need of acceptance and understanding, these individuals found themselves denied support, either because of lack of communication or because of miscommunication.

It seems a paradox that in the developmental literature one reads of the requisite need to move away from the established family unit to develop a more autonomous reality, (Loevinger 1976, as cited in Cavanaugh, 1990) and emotional independence (Erikson, 1982) while these individuals experienced the opposite drive. If, as developmental theory contends (Levinson, 1978), the need for autonomy is primary for young adults, it is premised on the assumption that one is able to integrate self and family and through this process come to a new understanding of the role of each. Having been denied support and assurance from the family during their earlier years, these individuals aspired to acquire that which had been withheld, namely a sense of belonging and value, which continued to be denied them. While autonomy was their primary goal, it was achievable through connection with others.

Life had little meaning without the love or support of someone -- a significant other (Carrigan, 1994; Diekstra, 1993; Frankl, 1959; Hendin, 1991; Maris, 1981; Shneidman, 1985). Although they would have preferred it being provided by family, a partner could also have been supportive, reliable, caring, providing security and feedback. None of the participants were able to maintain secure love relationships with a significant other. While being cared for and loved provided the foundation upon which these participants thought life had meaning and through which they sought to find the strength to confront the day to day struggles, they were unable to develop or acquire it. Without the security of knowing that they were valued,

life appeared meaningless and futile. Each felt profoundly alone (Maris, 1981), and separated from meaningful friendships and meaningful family interaction. The limitations of relationships come to be internalized and interpreted as a measure of self worth and value.

It was particularly poignant that most participants sought help through psychological or psychiatric counselling that proved unhelpful at best and harmful at worst. Lack of rapport with the therapist left them feeling invalidated, unacknowledged, and in some cases disempowered. Their pain was not heard and their fear was not acknowledged, the result of which was an increase in hopelessness and despair (Carrigan, 1994). Their perceptions were reinforced that change was not possible, that help was unavailable, and that they were essentially worthless people. Their perspective of their lives and struggles was seriously divergent from that of the objective observer. This discrepancy in understanding is a deficiency seldom addressed adequately in the literature (Leenaars, 1997; Shneidman, 1987, 1993a). Investigating, acknowledging, and understanding these differences has important implications for therapeutic intervention.

Communication

Communication became an issue of increasing importance for these participants during adolescence. Each felt unheard by family and/or peers. They were unable to articulate their needs in such a way that others responded appropriately either because of inadequate articulation or because of a lack of desire to communicate on the part of others. Behavior that was intended to communicate need was often misinterpreted by others. Miscommunication occurred frequently within the family whereas communication with peers, who had previously provided support, either deteriorated or diminished through mutual consent. Lack of ability to communicate effectively with either family or friends heightened and fostered a sense of alienation and separateness.

Participants utilized a variety of methods to communicate their needs,

their desires, and their distress. Maximal efforts to do all the things expected of them, which included being a good student, being well behaved and actively involved individuals, and seeking acceptance through career success, did little to improve the quality of communication or connectedness with valued others. Self-destructive behaviors were also used as a method of communicating distress. However, these behaviors tended to push people away rather than encourage interaction. Interactions became limited or restricting to others engaged in similar behaviors who were unwilling or unable to provide support. As the self-destructive behaviors escalated and effective functioning diminished, each participant became less able to articulate their difficulties but rather increased their acting-out behaviors as a means of sending a non-verbal message of distress (Maris, 1981).

Paradoxically, repeated rejections of attempts to communicate with family often had the effect of creating an environment in which withdrawal from others seemed necessary as a protective mechanism. Withdrawal from others, however, fostered an atmosphere that severely hampered communication. Feelings could only be expressed through anger and depression. The female participants particularly experienced difficulty dealing with emotions construed to be negative, and thus they felt restriction in their communication.

Lack of ability to communicate with others contributed to a significant sense of isolation, disruption, and alienation. As the perception of separateness from valued others and from the world increased, a sense of desperation developed. Life was perceived to be unbearable and major changes were required. Based upon prior experience, each believed that major change was impossible. Therefore future effort was perceived as futile. Desperation grew and a sense of resignation set in. The only way to end the cycle was seen to be suicide.

Relationships with others became increasingly important. The suicidal process involved relationships, connection to others, and meaningful interactions. It is evident that their stories were not about themselves as individuals in isolation, but rather as individuals in relationship; to the world, to valued others, and to themselves. Relationships

were needed to give meaning to life.

Control

Attempted suicide is often viewed as a selfish attempt to reach one's own goals without consideration for others or as an attempt to control the actions of others in order to produce an outcome that is suitable to only the person taking the action (Bancroft et al., 1979; Eddins & Jobes, 1994; Hawton, Cole, O'Grady, & Osborn, 1982; Hayes, 1993). Manipulation is understood as being synonymous with control. When reading this literature, an understanding of the discussion of control (manipulation) as blackmail or coercion is hard to avoid. An emotional response based upon perceived motivation may influence our understanding of what the behavior usually means (Bancroft, Hawton, Simkin, Kingston, Cumming & Whitwell, 1979; Lester, 1991). Understanding suicidal behavior as a manipulative tool provides the basis for negating the extent of an individual's distress or despair which clearly was the experience of those in this study. Rather than providing a framework within which the human condition of despair is more completely understood, it justified the minimization of the individual's need for understanding and care. This response from others intensified the suicidal individual's perceptions of being unimportant, invalidated, and minimized by others.

Shneidman (1985; 1993b; 1996) expanded the study of suicidal behavior by placing it within the framework of psychache, or unendurable psychological pain. Using suicide as a means of escaping pain, a common human need, is one of the four commonly discussed reasons for completed suicides (Gibbs, 1990; Maris, 1981). However it is typically not discussed within the context of attempted suicides because the unsuccessful suicides are usually construed of as less serious and manipulative rather than painful. In this study, the desire to put an end to psychological pain played a role in the participants' suicidal behavior in conjunction with desperation, lack of control, and inability to successfully resolve stressful issues. These participants felt that they were helpless in reaching resolution to the

problems they experienced except by ending their lives. They had no method of controlling their psychological pain.

There was a sincere belief by these individuals that they desired to end their pain and they chose suicide as the last resort to reach resolution. At the same time, they sincerely desired to live constructive, meaningful lives (Maris, 1992; Shneidman, 1996). The choice to attempt suicide was not an either/or decision -- to live or to die -- but rather was a decision that life needed to be meaningful and that the unendurable pain must cease. The life experiences of the participants of this study led each of them to believe that they were incapable of successfully completing these developmental tasks. Their experiences led them to believe that control was external to them, and that personal control was unattainable.

Lack of control or perception of lack of control permeated all aspects of their lives, including control of thoughts, feelings, physical responses, behavior, and environment. Control of internal responses was lacking, as was control of external circumstances. Attempting to end their life through suicide was therefore seen by the participants as an adaptation to life. It was the last resort in a series of efforts to take control of, and manage their environment. This is not manipulation in the pejorative sense, but rather is an attempt to define the individual's relationship with the world (Gibbs, 1990). The suicidal attempt for these participants was made in an effort to gain control over their own lives (Hendin, 1991), and not as an attempt to control the lives of others.

Contrary to some reported findings (Hawton et al., 1982) most of the participants viewed themselves as "failures" prior to their attempt (Hughes & Neimeyer, 1990). Engaging in the suicidal behavior gave each individual the sense that they were finally in control of their destiny, a perception previously lacking. Control of living or dying provided mastery of their situation and diminished their sense of failure. Most participants had stored drugs without a direct understanding that they were preparing to reject life. The act of stockpiling provided the perception of control. They felt their actions made a difference. No longer were they at the mercy of others who would ultimately reject them further. Making the decision to end an

impossible situation, rather than waiting for someone else to end it or make a change, is a consistent observation with previous studies (Hendin, 1991; Shneidman, 1985, 1987, 1993a).

Consistent with past research (Beck, 1986; Beck et al.,1985; Beck et al., 1993) each participant experienced extreme hopelessness, helplessness, and ultimately, futility. The future promised only more of the same. Four participants moved beyond depression into despondency, then despair, then desperation (Hendin,1991). The desperation resulted from an understanding that life would be impossible without a change but each felt hopeless about the possibility of change. Suicide was the last available option as no other alternative was seen to address the issues that overwhelmed them and had taken control of their lives.

Developmental Perspective

Following completion of the analysis of results, the researcher investigated the developmental literature in greater depth in an attempt to place the related experiences within a developmental context or framework. This search proved to be frustrating. Some theories (Erikson, 1978; 1986; Levinson, 1978) focus on developmental tasks such as career establishment, establishing intimate relationships within traditional roles of husband, wife, father, mother, adjusting to children within the home in isolation from emotional development, whereas others focus on behavior, cognition, and the environment, without directly addressing affect.

It is interesting to note that four of five participants indicated that they had attempted to take their lives between the ages of 10 to 15, and again in early adulthood. There appear to be important parallels between these two age ranges. Both are transitional periods of huge significance in which important physical, cognitive, and emotional growth and development occur over a relatively short period of time. Each requires changes in roles, exploration and discovery of new thoughts and feelings, understanding the world in a larger and more comprehensive manner, and the development of strategies to deal with increasingly difficult social demands. The rapid

change that occurs over a relatively short time frame often results in disruption and feelings of personal instability.

Although there is a consensus that transitional periods are difficult, little research emphasis is placed on the stage of late adolescence to early adulthood. Demick (1996) indicated that the transition from adolescence to adulthood requires more adjustment and is comprised of more changes than any other developmental stage in life.

Since the ages of 20 to 24 are a period of transition between adolescence and adulthood, much of the research into suicidal behavior has combined adolescent and young adult groups together (Leenaars, 1997). This leaves open the question whether the results are specifically related to either the younger or older age group which face different developmental challenges. A 13 year old has little in common developmentally relative to a 23 year old. In addition, the societal demands and expectations are significantly more complex for the young adult than for the early or mid-teen. Adolescents are generally expected to develop a sense of identity whereas young adults are exploring and adopting new roles that refine their sense of identity (Erikson,1982). Concurrently, they are dealing with the emotional aspects associated with these processes and lack the social support that is provided for adolescents.

Teenagers in our society are mandated to attend school or a learning institution until a specified age. Generally, students are engaged in the education system until approximately ages 17 to 19 at which time they begin to explore the adult world. Throughout the school years, teens are somewhat segregated from the rest of society and are dealt with as a group. Services are provided by teachers, peer support groups, school counsellors, coaches, and instructors, and are available and accessible though the educational institution and children's services. Adolescents also generally continue to live within the family where they are provided with guidance, emotional, and financial support. Although they may aspire to being independent, they are not expected to be (Erikson, 1978). Peer interactions and connections tend to be based upon shared experiences either in school or through special interests. Teens are surrounded by large numbers of

individuals whose interests, roles, and actions are similar in nature.

Moving into adulthood requires that adjustments and alterations be made in life style, type and extent of participation in various endeavors, assuming and mastering new roles, and in becoming autonomous (Erikson, 1978; Levinson, 1978). The cohesiveness of life experience typically associated with the teen age years is left behind. While the roles and expectations of adolescence are generally understood and adhered to, they are not as clearly delineated in adulthood. Young adults begin to accept the challenges of self-reliance, financially and emotionally, and are required to find a new environment or niche in which they can function. Generally the support of either family or friends spans the transitional years, although some adjustments are made to accommodate the new reality. New adult support systems are developed over time and require a conscious effort to develop and maintain.

What is unique about the young adult years is the internal drive toward developing autonomy. Societal expectations reinforce that the individual will become independent from family, will provide for himself or herself financially, will find a suitable role and place within the adult world, and will accept personal responsibility for the events and situations that occur within life. This transitional period requires more stressful life changes than at any other stage in life (Smolak, 1993). Although a new source of stability is frequently constructed along with independence, this was not the experience of these participants. They were unable to provide themselves with stability either through the establishment of a supportive peer group or through career choice. Life became increasingly unstable. As no new structure was developed, the old structure gained increased significance.

The process of separation from the family is a process of trial and error; exploration, evaluation, and experimentation. It can be concurrently frightening and exhilarating and requires faith, optimism, hope, and confidence in facing new challenges. These participants had few or none of these qualities as they attempted to adjust to increasing life demands. Interactions within the family remained static so that issues continued to be unresolved, relationships did not accommodate changes, and the road

travelled into finding a place in the adult world was filled with obstacles. The conflict between feeling dependent and longing for autonomy created a loss of integrity.

The individuals in this study experienced difficulty with choosing appropriate roles, and continued to function within roles that allowed them to deal with unfinished issues confirming previously reported findings (Erikson, 1978; Heikkinen, Aro, & Lonnqvist, 1994; de Man, Leduc, & Labreche-Gauthier, 1993). Consistent with Erikson's developmental struggle involving intimacy and isolation (1982), they discussed the suicidal process as a struggle between connection and isolation. Erikson's theory is premised on the assumption that previous developmental stages have been successful.

Maris (1981) claimed that suicide attempters are individuals who have failed to master the appropriate developmental tasks of the different life stages. Consequently they are more likely to experience failure through transitions which leads to developmental stagnation. The experiences of the participants of this study appeared to be consistent with Maris' hypothesis as they identified struggles more associated with the resolution of old relationships rather than the development of new relationships.

Each person is a complex integrated whole. As such, an understanding of the developmental process of suicidal behavior must be considered within the context of understanding how it relates to other aspects or dimensions of development. Decisions which appear to have major implications on the course of the individual's life, such as career options and opportunities, educational goals, and lifestyle, are expected and encouraged by society. For the participants of this study, the demands of changing roles and structures and the demands of dealing with emotionally charged issues without an adequate support network was overwhelming and felt unattainable.

Implications for Counselling

Implications for counselling will be addressed from two perspectives. A short discussion concerning the preparation of the therapist to deal with

suicidal clients will be followed by a discussion addressing therapist/client interaction.

Because suicidal behavior has historically been a taboo subject, there is much that is misunderstood about the phenomenon. These misconceptions need to be specifically addressed in training programs for therapists. Suicidal behavior and suicidal thoughts can easily be overlooked or minimized in therapy if the therapist has not been trained to ask questions about these specific behaviors. Fear of dealing with suicidal clients is not uncommon and is often rooted in lack of familiarity with the phenomenon. Therapists can be provided with direct instruction that allows them to develop a deeper understanding of what is and what is not appropriate to attempt with suicidal clients.

As a large proportion of individuals seeking counselling suffer from depression and desperation, it is likely that a therapist will regularly encounter issues of severe depression, suicidal thoughts, and suicidal behaviors in their clients. Yet, too often, the dynamics and issues that arise from emotional disorders are overlooked and go unexplored in the learning environment unless the aspiring psychologist is enrolled in a program specifically identified as oriented to a clinical population. To adequately prepare to deal with the population that seeks therapy, the therapist needs to have a firm foundation not only in theory but also in emotional function and dysfunction regardless of the orientation of their program. Understanding both the crisis and continuing therapy models of therapeutic intervention would be instrumental to addressing the immediate and pressing issues when confronted by a suicidal individual in crisis, as well as those unaddressed and unresolved issues that may continue to be problematic and eventually contribute to the individual engaging in suicidal behavior in the future.

For those working within specific age populations, geriatrics or young adults for example, an understanding of the dynamics of suicidal behavior within the developmental context of that age group is important. Presenting issues have differential impact dependent at the individual's life stage as issues are interpreted within the context of life experiences, emotional

functioning, coping skill and problem solving strategy, and fundamental beliefs.

For those in a suicidal state, the development of a sense of connection is critical and urgent. The therapeutic relationship can provide a safe and secure framework in which the client is able to connect and communicate with another person in a meaningful manner and begin to expand and explore the options that are available to solve their problems. The development of a meaningful therapeutic relationship is critical in that those in distress have turned to "the expert" for assistance and support. If the interaction mirrors those experienced in daily life, the suicidal client may reinforce the perception that they are inadequate persons, unsuccessful in all attempts to connect with others.

Rapport can best be established between therapist and client through empathic listening and positive regard as the client discloses their reality and feels that it is heard and validated. It is critical that a therapist establish an alliance with the suicidal individual in which understanding, concern, and support can be provided. Given the nature of suicidal behavior in young people specifically, it is imperative that successful treatment include attention to both the immediate crisis situation and the underlying problems that precipitated the attempt.

The development of good clinical interview skills that, while facilitating the development of rapport, allow the therapist to obtain the most critical information relevant to the specific client, is paramount. While this may be true for all presenting clients, it is more critical for those who are suicidal. In subsequent sessions, the reality of the client's life experiences should be explored in depth while immediate, crisis related issues are addressed. Crisis intervention can often be accomplished within a relatively limited time frame, whereas the underlying issues related to the development of the suicidal behavior will likely require a longer intervention period.

Conflict is an inherent part of life. Effective coping and problem solving skills are prerequisites for successful conflict resolution. The larger the repertoire of strategies that a person has to chose from, the more likely

they are to successfully negotiate the challenges of life. Therapy provides a supportive environment in which coping strategies, stress management, and problem solving skills can be addressed. Coping and problem solving skills are developed within a social context in which issues are discussed, options explored, alternate interpretations are examined, decisions are make and implemented, and social support is provided if initial attempts to resolve issues are unsuccessful. Therapy provides a venue within which personal boundaries of behavior can be expanded, options and alternatives generated, and the client supported so that they can maintain the courage necessary to deal with personal issues.

The impact of cumulative losses on life perspective may be an important focus for both therapist and client. Loss results in grief, therefore it is possible to conceive of suicidal behavior as the end of a grieving process. This conceptualization could provide a valuable framework within which to develop an effective therapeutic strategy. Therapists must be prepared not only to assist in the development of a support system, but also establish long term goals for resolving the underlying issues upon which the suicidal behavior developed. The ultimate goal must be to establish independence through the therapeutic process.

Implications for Education

The schools provide one of the first environments that are consistent between children in which they can be observed and monitored in a systematic manner by trained professionals. Based upon the findings of this study, early intervention that addressed the emotional difficulties of these individuals may have made a difference to the course that their lives took. Teachers and school staff have a unique opportunity to build relationships with children that demonstrate care and concern for the individual.

As an institution, the mandate of the education system has historically been to provide an academic education to children and is one of the few stable institutions that functions in the lives of children. In recent years, the mandate of issues that are addressed within the education system has been

expanded. Teachers, administrators, and support staff are expected to deal with broader life issues than they have in the past. As the roles and responsibilities of school are modified, it is important to recognize that they have become more than academic settings. School environments and school personnel contribute substantially in directing and guiding the emotional and psychological development of the child. Teachers and support staff provide valuable role models and a stabilizing influence in the lives of many children who experience life disruptions and significant changes and can make a valuable contribution to the emotional health and well being of these children. The more that those who work directly with children understand both normal and abnormal growth and development processes experienced in childhood and adolescence, the better able they are to identify and address issues that are problematic for children. A solid foundation in childhood growth and development acquired in the process of becoming a teacher would be of major benefit.

As many children are, or feel, isolated from adult support, availability of trained counsellors within school settings would be beneficial. Counsellors should have received formal training and supervision in dealing with the issues of childhood and adolescence specifically, in addition to dealing with broader issues of family functioning, emotional distress, coping skills, and problem solving strategies. In conjunction with trained counsellors, teachers who teach life skills and coping mechanisms in health classes need to be particularly aware of personal differences and individual styles in an effort to identify those children or adolescents who are struggling emotionally. This can be accomplished by being trained to observe and identify particular types of behaviors and thinking patterns that are problematic for the child. As much as possible, those children who are identified as struggling emotionally should be directed to services to assist them.

In addition to having trained counsellors within the school, junior and senior high schools would benefit from encouraging peer counselling and peer support groups that are able to reach out to adolescents who feel or appear to be isolated from others or in distress. Participation and connection

with peers was identified by the participants in this study as being highly valued but difficult to attain. Although many schools provide a plethora of activities, clubs, and organizations to belong to, it may be difficult for those already feeling isolated to attempt to join an established group. A peer support group may be able to provide the necessary bridge to meaningful peer connections.

School districts may be well advised to have established crisis intervention programs and personnel available on an as needed basis. Currently, many schools provide this service to address distressing issues, ie. the accidental death of a well known student because of drunk driving, the suicide of a student within the student body, a natural disaster that creates emotional upheaval for a large number of the students. Crisis intervention personnel have the training and knowledge to deal as effectively as possible with a given situation in an attempt to alleviate emotional distress as quickly as possible as well as to deal with issues effectively so that the healing process is nurtured and encouraged to occur as quickly as possible.

Teachers and support staff should be provided with ongoing in-service training that enhances their ability to deal with the emotional issues that many children and adolescents present with within the school setting. Simple strategies such as listening skills, asking open ended questions, and appropriate demonstrations of care and concern are easily taught and can be incorporated into the adult's daily interactions with all children and adolescents, particularly with those at risk or who appear isolated from adults and/or peers.

Most adults return to educational institutions at some point in their life for upgrading, training or retraining. Attendance at vocational and junior colleges frequently occurs prior to the age of 35. Therefore, it would seem important that these institutions provide both academic and personal support services and that these services be readily accessible for those who require them. For those who do not return to learning institutions, it is important that community resources and services be available on an "as needed" basis to provide assistance when distressing personal issues

require intervention. In order for these to be appropriately utilized, they must be known to the general public as useful and attainable services.

Implications for Future Research

A variety of research projects could be considered based upon the findings of this study. Another qualitative study concerning the process of developing suicidal ideation and suicidal behavior could investigate the similarities and differences between males and females in the late adolescent and early adulthood years. Differences in gender issues may account for the discrepancy between attempt to completion rates in the under 30 age group. Considering suicidal behavior and ideation within the context of developmental stages may be of assistance in creating the foundation for effective prevention and intervention programs which target specific age groups.

Loss was an important identified factor for the participants of the current study. Further exploration of the role of loss and cumulative losses could provide insight into the phenomenon of suicidal behavior, particularly if the impact of cumulative losses on those that are suicidal was contrasted to those who are not suicidal. Further, if cumulative losses result in grieving, understanding the process of grieving within the context of suicidal behavior would be instructive. Does unresolved grief or being stuck within a particular place in the grieving process have an impact on suicidal ideation or suicidal behavior? Does developmental stage play a role if grieving is involved in suicidal ideation and decision making?

Qualitative methodology allows for the richness of experience to be investigated and understood. Because so little emphasis has been placed on the early adult group who are negotiating a difficult life transition, specifically ages 20 to 24, there is much to be gained by future studies that qualitatively investigate issues related to that transitional stage such as stress management, coping skills and problem solving strategies, role of social support, and interventions that make a difference.

Summary

This research project was an attempt to understand the meaning of the suicidal process for the individuals who participated. The findings indicate that suicide was a process for these participants that had begun during childhood and resulted from an accumulation of unresolved emotions, thoughts, and beliefs that developed from real and perceived negative life experiences. The emotional distress that each experienced built beyond a level to which each individual felt they could emotionally bear or adequately resolve. The future held no promise of improvement or change, but change was perceived as being absolutely essential for the continuation of life. The suicide attempt became the last available option as a resolution to unsolvable problems and unresolved emotional pain.

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APPENDIX A

PURPOSE OF THIS STUDY

PURPOSE OF THIS STUDY

The purpose of this study is to understand the process that persons who have attempted suicide have undergone in making the decision to end their life. It is being conducted as a Doctoral Dissertation by Robin Everall , Provisionally Chartered Psychologist, under the supervision of Dr. B. Paulson from the Department of Educational Psychology, University of Alberta.

Suicide is now the second leading cause of death after accidents in young people. The increase in suicidal behavior and suicide attempts over the past decades has been a subject of particular concern to researchers, clinicians, and the general public, and has been well documented. It has been recognized that suicidal risk increases with increased age, placing young adults at higher risk for suicidal behavior than late adolescents.

Attempted suicide includes behavior that stems from a serious intent to die, but because of an unplanned event, the individual has been unsuccessful in their effort to end their life. The purpose of this study is to investigate the thoughts, feelings, and events that contributed to suicide attempts in young adults. In this study, young men and women between the ages of 20 to 24 who made the decision and took action to end their own lives will be interviewed by the researcher.

Each individual attributes meaning to important personal events, and has their own unique understanding of their world that contributed to their decision to engage in suicidal behavior. The point of view of the person most intimately involved, the suicide attempter, is critical in developing a deeper understanding of suicidal behavior as each individual has their own explanation and purposes for attempting to take their life. The goal of the proposed research is to understand the meaning of the actions and experiences that lead up to the suicidal behavior for each of the participants in this study. Participation in this study will require the willingness to discuss your perceptions and perspectives about your experience with the researcher with as much detail as possible.

Participation in this study is strictly voluntary. Participants have the right to withdraw from the study at any time.

APPENDIX B

CONSENT TO PARTICIPATE FORM

CONSENT TO PARTICIPATE

I am aware that the purpose of this study is to understand the experience of having attempted suicide. Through interviews, I will be asked to describe my suicide attempt experience in as much detail as possible. The study will be conducted as a Doctoral Dissertation by Robin Everall, Provisionally Chartered Psychologist, under the supervision of Dr. Barbara Paulson, Professor, from the Department of Educational Psychology at the University of Alberta.

I agree to participate in the study and to be interviewed about my suicidal experience. I understand that two interviews of about one to two hours will be tape recorded. I understand that participation in this study is strictly voluntary, agree that I have been given a comprehensive explanation of the purpose and nature of this research, and agree that I have had all relevant questions regarding the research answered by the researcher. I understand that I have the right to refuse to answer any question, to end the interview, and/or withdraw from the study at any time without explanation. I am aware that there is a risk that in discussing my experiences, distressing feelings and memories may be triggered. If I indicate that I require the services of a counsellor, Robin Everall will suggest resource persons that I might contact.

I understand that in order to assure confidentiality of personal information and anonymity, all audio tapes will be kept in a safe and secure location accessible to only the researcher. I will be referred to by pseudonym only in all written material that results from this study and details will be changed so as to make my identification impossible. Audio tapes will be destroyed once the study is completed. Transcripts will be maintained as confidential files. If they are to be used for any additional analysis in future research, separate ethical approval by an Ethics Committee will be required.

Any questions I have about the study at any time will be answered by Robin Everall (phone 492-2483) or Dr. B. Paulson, supervisor of the project (492-5298). I also understand that at my request, she will discuss the results of the study with me when completed.

On the basis of the above information, I _____ agree to participate in the above study.

_____

Signature of Participant Date

_____

Witness Date

APPENDIX C

GENERAL INTERVIEW GUIDE

General Interview Guide

1. If you were to relate your suicidal experience to me, where would you begin?
2. What was happening in life prior to and during the period of time that you were suicidal?
3. What did you do?
4. What did you want to achieve?
5. What kind of responses did you receive from others?

Discussion of emotions, thoughts, events, situations, activities, communications with others, impact of behavior prior to and during suicidal period.

APPENDIX D

ADVERTISEMENTS SUBMITTED TO COMMUNITY SERVICE ANNOUNCEMENTS

April 26, 1996

CFBR Radio

BY FAX #444-XXXX

Please include the following information in your community service announcements:

VOLUNTEERS NEEDED FOR A RESEARCH PROJECT. Did you engage in suicidal behavior between the ages of 20 - 24? Have you recovered from SUICIDAL thoughts and behavior? Would you be willing to participate in a study exploring suicidal thoughts and behavior in young adults? Participation is strictly confidential. Please call: Robin Everall, 970-0546 or Dr. Barbara Paulson, University of Alberta, 492-5298.

I would appreciate it if you could run this notice until the end of May. Thank you for your assistance.

Robin Everall, M.Ed.

APPENDIX E

ADVERTISEMENT PLACED IN NEWSPAPERS

VOLUNTEERS NEEDED FOR A RESEARCH PROJECT. Did you engage in suicidal behavior between the ages of 20 - 24? Have you recovered from SUICIDAL thoughts and behavior? Would you be willing to participate in a study exploring suicidal thoughts and behavior in young adults? Participation is strictly confidential. Please call: Robin Everall, 970-0546 or Dr. Barbara Paulson, University of Alberta, 492-5298.

APPENDIX F

SAMPLE OF ANALYSIS OF THEMES

Appendix F
Illustration of Transcript Analysis

SIGNIFICANT STATEMENT	LABEL	THEMES
And it was you know, it was murder living with him because he was so critical and, I mean he was ill but when you are 14 you don't see it that way. You take everything, I took it very personally and he pretty much eroded my self worth on a day to day basis, and I was scared to come home from school, because I didn't know what I was you know, in for, or what he was going, he was constantly putting me down. I think it probably goes under the category of emotional abuse, like psychological abuse.	felt targetted criticized fear of home felt overpowered felt unprotected defenseless self as inadequate home felt insecure	Relationship with Others Self Worth Rejection
I went to a counsellor and talked to her about it and I decided to write my mom a letter and tell her about it because I couldn't do it face to face. She's got way too much power over me and I couldn't have done it then. So I sent the letter and she sent a message back saying well thanks for that doozey and no, I'm not ready to deal with this shit. I was hurt, angry and hurt.	intimidated by mother fear of disclosure mustering courage to disclose looking for reassurance looking for support felt rejected felt betrayed	Anger Alienation Rejection Relationship with Others
I always felt like I was different in some way, that I never fitted in anywhere, I just didn't feel like I belonged anywhere.	self separated from others felt different felt alone	Alienation
You're trying to understand yourself and there's another world where you're trying to relate with the rest of the world the way it's supposed to be. As you get older you're trying to deal with being accepted in the world and trying to find a balance.	understanding self relations with others finding a place in the world self-acceptance acceptance from others living in two worlds	Two Worlds Self Awareness Relationships with Others